

STUDENT COURSE BOOK

Introduction To Health Care and Human Services

**For the Personal Support Specialist (PSS) and
Certified Nurses Assistant (CNA) Training Program**



The Bureau of Elder and Adult Services
Maine Department of Human Services

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Introduction

Welcome to the Health Care and Human Services training program. This course is designed to meet the education needs of Personal Support Specialists (PSS), and Certified Nurses Aides (CNAs) in the state of Maine. It is the latest in a series of training programs designed to teach the skills, knowledge and values needed by staff in the health care and human service fields. We are pleased that you have joined us for this training. This course will introduce you to many subjects that apply to a range of work situations. As a direct service worker, you will assist people in the community who require a wide range of services, skills, and supports in multiple settings.

The old idea of “care taking” has disappeared. We are in a new era of service delivery that is far more complicated and challenging than ever before. All of us, whether experienced or new to the profession, will need new skills and knowledge to meet these challenges. This course has been designed to help you do just that.

■ Personal Attitudes Toward Learning

This training program consists of several elements. Some are designed to introduce you to new information and allow for discussion and sharing of ideas. Others will consist of sessions where you will practice new skills with guidance from your instructor. In addition, the course will provide opportunities to test your knowledge and add to your present understanding of the work settings in which you may practice. Although some of your work will be evaluated, this course does not exist to judge people. Whether you are experienced in this field or just starting out, you can learn something new and improve how you do your job.

Everyone learns through trial and error, so it is OK to make mistakes or to question old assumptions during this course. Your instructor will encourage you to explore new ideas and new ways of doing your job. It's better to do this now than when you are back at work with the people you serve.

To gain as much as possible from your time here, you should be actively involved. Sometimes, people hold back, say little, and expect to acquire skills merely by sitting passively in a classroom. Occasionally we're afraid we won't look good if we make a mistake. These attitudes really get in the way of learning and personal growth. We acquire new skills and new information by getting involved: by asking questions, by making comments,

through sharing ideas with others in the course, and by reviewing course materials between sessions. Your instructor is here to guide you, but **you** are responsible for how much you learn and grow.

Here's how each session will proceed. During each course meeting, your instructor will present a series of key ideas from your course book related to a particular issue. She will acquaint you with certain important principles, practices, and methods in various human service and health care settings. Then, you will have time to discuss each concept or method and to understand it thoroughly before moving on.

You also will have an opportunity to participate in activities or exercises. On occasion, your instructor will offer you opportunities to demonstrate skills and to receive feedback on your performance. Support and guidance will be provided where there are performance areas that can be improved.

■ **Attendance and Readiness**

The short, intense nature of this training requires that you be present during *all* course sessions. Missing some sessions and casually dropping by for parts of others is not allowed. It is vital that both you and your employer understand that you'll achieve your highest level of training through regular attendance, uninterrupted by changes in your work or personal schedule.

You can benefit most by arriving on time and being committed to learning. Be sure to bring your course book and other required materials to every session. Be sure to read *in advance* the sections of your course book that will be used in each day's session.

■ **Homework**

Your instructor may ask you to read or study some material between course sessions. These homework assignments will be brief but are vital to understanding and remembering course ideas, methods, and concepts. It's often difficult to find time for additional study. You will need to actively plan for and set aside study time when your instructor requests that you do so. This will help you stay up to date on course information and prevent you from forgetting concepts and skills you've learned. To gain the full benefit of this training, you need to commit to learning the information. Do you live near any of your course mates? It may be useful to study together when possible, as this approach boosts learning and retention. It may also be possible to car-pool to training sessions and discuss the course together while traveling.

If you work with other course participants, you are encouraged to arrange informal meetings to discuss course materials and concepts.

■ **Emerging Standards**

Perhaps you've asked yourself "why do we need to study these particular skills and methods?" In many states, including Maine, standards of education and training for unlicensed people working in health care and human services did not exist until fairly recently.

Nationally, the federal government, institutions of higher learning, groups of direct care professionals, and communities have begun to push for uniform training relevant to the services performed by today's direct care personnel. Thus, the training you will receive in this course reflects newly emerging national and local standards.

■ **How to Involve Yourself in This Program**

Parts of this course may appear to repeat training and previous coursework that you have already completed. In these circumstances, you should take advantage of the opportunity to provide insight and examples of real-life situations to the rest of the participants. This course takes an approach that is structured, but informal; detailed, but open to new ideas; carefully planned, but also flexible and experimental. *We want you to succeed in this course.*

■ **You will do your best in the course if you do the following:**

- Students who complete the entire PSS training successfully and who start CNA training Take notes on the material your instructor presents during every session. Write down key ideas.
- During group or work sessions, take notes that capture the ideas discussed including your own contributions to the group's effort. Working with others is an important source of knowledge and skills.
- If you are unclear about anything, ask questions. *Go ahead and ask.* We learn by questioning and clarifying.
- Participate in the group discussions. By sharing ideas, you test your understanding and add to your knowledge. Not participating decreases learning.
- Compare notes and ideas with fellow trainees. They can add to your knowledge and you to theirs. *Talk shop!*
- Set aside time to review the course book at home each day to keep up with the information. Study and discuss concepts with fellow students. Always come to each session having read the accompanying section of your course book.

■ A Note About Terminology

In health care and human services, there are many terms that are used to refer to people receiving services:

1. Consumers
2. Clients
3. Patients
4. Service Recipients
5. Residents

For the most part, health care and human service providers use these words interchangeably in different settings, but for the purposes of this course we will use the term “consumer” most often to refer to people receiving services.

The word “consumer” is now preferred in many areas of health care and human services because it emphasizes the choice that people have over the services they receive. The term “consumer” helps service providers to remember that people do not passively receive the services we give them, but rather actively use (consume) services they have chosen.

■ Special information regarding PSS course completion

- Successful completion of the PSS training qualifies an individual to provide direct support to consumers in assisted living programs, residential care facilities, adult day services programs and home care settings.
- Students who complete the entire PSS training successfully and who start CNA training within 2 years may receive credit for Modules 1-6 of the CNA training.
- Students who complete this training and who enroll in the Behavioral Health Sciences associate degree program at SMTTC are eligible to receive credit for this training toward the degree.
- The training includes 15 modules. A minimum of 50 classroom hours of training is required to complete the modules. At the discretion of the instructor, additional hours of training may be required depending on the number and needs of students, teaching techniques and other learning opportunities.
- The training is accompanied by the textbook, *Personal Care in the Home* (1996) Morton Publishing Company, International Standard Book Number 0-89582-315-2. To order, call Morton Publishing at 1-800-348-3777.

- Students are required to pass a final exam and module exams. No open-book exams are allowed. Students are also required to demonstrate the ability to perform identified skills competently. Instructors are required to make reasonable accommodations for students with disabilities.
- Grading protocol:
 - 30% class participation including homework assignments;
 - 30% skills demonstration (Pass=100%);
 - 30% module tests (10 questions drawn from the final exam pool; passing grade is 70. Students may retake a module test two additional times. The highest grade that a student may receive on a module test “retake” is 70.)
 - 10% final exam (50 questions distributed among the modules; passing grade is 70. Students may retake a final exam two additional times. Final exams must be proctored by the instructor or his/her designee.).
 - Passing grade for the PSS course is 80.

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Module 1: Entering the Health Care and Human Service Fields



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Describe the different kinds of health care and human service programs available to consumers in Maine;
- ➔ Describe the important values in health care and human services; and
- ➔ Describe the scope of career options within the health care and human service systems (e.g., the types of employment available).



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Acute Care Hospitals
- Nursing Facility (NF)
- Assisted Housing Programs
- Assisted Housing Services
- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Residential Care Facilities
- Assisted Living Services
- Assisted Living Programs
- Independent Housing with Services
- Home and Community-Based Services
- Maine Department of Human Services (DHS)
- Bureau of Medical Services (BMS)
- Bureau of Elder and Adult Services (BEAS)
- Behavioral and Developmental Services (BDS)
- Medicare
- MaineCare (Medicaid)
- Veteran's Affairs (VA)
- Third Party Payers
- Private Pay
- Person Centered
- Homemaker
- Personal Support Specialist (PSS)
- Certified Residential Medication Aide (CRMA)
- Certified Nurses Assistant (CNA)
- Certified Nurses Assistant – Medications (CNA-M)
- Home Health Aide
- Licensed Practical Nurse (LPN)
- Registered Professional Nurse (RN)
- Chief Executive Officer /Administrator

Health Care and Human Services in Maine

There are essentially two broad categories of health care and human services in Maine: those that provide short-term (acute) care to people and those that provide long-term care:

1. **Acute Care Hospitals**

Acute Care Hospitals provide short-term care for individuals who need the highest level of medical care – for example, for a serious illness, accident, or surgery. Hospitals have teams of health care specialists who oversee the consumer's care and meet his/her acute needs (e.g., doctors, nurses, etc). Some hospitals also provide health care at a slightly lower level, but this level of care is still higher than that provided in a nursing home.

2. **Nursing Facilities (NFs)**

A **Nursing Facility** (NF) is a facility licensed under state law to provide health-related care and services to individuals who do not require acute care (e.g., in a hospital) but whose mental or physical condition requires services above the level of personal care (bathing, dressing, etc).

Nursing Facilities provide services to people who need skilled nursing care or care under the direct supervision of a nurse:

- 24-hour care including medical, nursing, dietary, pharmaceutical services, and an activity program.
- In consumer-care for people who need skilled nursing services and/or supportive care.
- Personal care such as proper positioning in bed or chair, bed baths, treatment of skin irritations (skin ulcers), assistance and training in self-care for feeding, grooming, and toileting activities.

Cancer (newly diagnosed) and cerebrovascular accidents are examples of conditions consumers might have in Nursing Facilities.

Assisted Housing Programs

In Maine, **Assisted Housing Programs** provide room, meals, and staffing services tailored to the particular needs of each consumer. The staff services include 24-hour responsibility for the well being of the consumers.

Assisted Housing Services (i.e., services provided by Assisted Housing Programs) may include, but are not limited to the following:

- Personal supervision and awareness of a consumer's general whereabouts, even though the consumer may travel independently in the community; and, observation and assessment of each consumer's

functioning or behavior to enhance his or her health or safety or the health or safety of others.

- Protection from environmental hazards including limiting risk in the physical environment to prevent unnecessary injury or accident.
- Assistance with Activities of Daily Living and Instrumental Activities of Daily Living:

Activities of Daily Living (or ADLs) are tasks routinely performed by a person to maintain their bodily functions, including locomotion, dressing, eating, toileting, bathing and personal hygiene.

Instrumental Activities of Daily Living (or IADLs) include, but are not limited to meal preparation, taking medication, using the telephone, handling finances, banking and shopping, light housekeeping, heavy housekeeping and getting to appointments.

- a. Administration of medications and tasks such as reading labels for consumers, observing consumers taking their medications, checking the dosage, removing the prescribed dosage, filling a syringe and administering insulin and bee sting kits (when permitted) and the maintenance of a medication record for each consumer.
- b. Diversional, motivational, or recreational activities that respond to consumers' interests or which stimulate social interaction, both in individual and group settings.
- c. Dietary services including the provision of regular and therapeutic diets that meet each consumer's minimum daily food requirements.
- d. Nursing services.

Consumers in assisted housing programs are primarily older adults, people with mental and physical illnesses, and people with developmental disabilities such as mental retardation.

The large growth in the number of these homes in recent years in Maine, and elsewhere in the country, has been caused, in part, by an expanding aging population and consumer preference for residential alternatives to nursing facility care.

De-institutionalization of people with developmental disabilities and mental illness coupled with the desire to prevent unnecessary nursing home placement will serve to further expand the need for this type of care.

There are many different types of Assisted-Housing-Programs in Maine, which provide some or all of the available Assisted Housing Services:

1. Residential Care Facilities

Residential Care Facilities are houses or other places that provide consumers with **Assisted living Services** (ADLs, IADLs, Medication administration, and nursing Services). Residential Care Facilities provide housing and services to consumers in private or semi-private bedrooms in buildings with common living areas and dining areas. However, they do not include licensed nursing homes (which are licensed by the DHS - Bureau of Medical Services) or supported living arrangements certified by Behavioral and Developmental Services (BDS).

Residential care facilities are usually classified into levels (e.g., Level I, Level II, etc.). This helps the state to group residential care facilities by size for purposes of regulating staffing, fire safety, and need for formal policies and procedures.

2. Assisted Living Programs

Assisted Living Programs are residential housing programs that consist of private dwelling units with an individual bathroom and an individual food preparation area, in addition to central dining.

Assisted Living Programs provide a comprehensive program of supportive services including meal delivery, housekeeping and chore assistance, case management and other services that assist tenants in managing the *activities of daily living* (e.g., bed mobility, transfers, dressing, eating, toileting, bathing and personal hygiene) and the *instrumental activities of daily living* (e.g., meal preparation, using the telephone, handling finances, banking and shopping, light housekeeping, heavy housekeeping and getting to appointments). Assisted Living Programs may also include personal care assistance, medication administration, and nursing services.

3. Independent Housing with Services

Independent Housing with Services are almost identical to Assisted Living programs. They serve consumers in private apartments in buildings that include a common dining area. Like Assisted Living Programs, they assist consumers with ADLs and IADLs. The major difference between the two is that Independent Housing with services does not offer medication administration or nursing services.



Home and Community-Based Services

In 1993 Maine adopted a policy to reduce reliance on institutional long-term care and to offer more safe, affordable choices for consumers and families. Putting the policy into practice meant new kinds of home and community-based services, changes in how long-term care programs are administered,

major changes to program policies, and “growing” the system to serve more people.

Reliance on nursing home care has declined dramatically. The total number of persons receiving long-term care services has increased from 19,803 in 1995 to 25,455 in 2001. The majority of persons now receive care at home or in assisted housing programs. Because home care and assisted living generally cost less than institutional care, Maine has been able to serve more people with only modest increases in total spending.

1. MaineCare Benefits

The state’s MaineCare program has developed alternate programs that provide some home and community-based long-term care services for those people who would otherwise qualify for institutional care. These programs require a *waiver* from the federal government.

Maine currently has three types of home and community-based waivers:

- A. Home and Community Benefits for the Elderly and for Adults with Disabilities.
- B. Persons with Mental Retardation (BMR) Waiver.
- C. Home and Community Benefits for the Physically Disabled.

The first two categories of Waiver programs offer a full range of home and community services. The last benefit allows for self-directed personal care and case management services to persons with physical disabilities.

2. In-home and Community Support Services

Home and Community-Based Services encompass a wide range of health care and human services. These services are delivered at home to recovering, disabled, chronically, or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living and instrumental activities of daily living (dressing, cooking, cleaning, etc).

In order to qualify for in-home and community support services, you must be medically and financially eligible for the program.

Home or community-based care is appropriate whenever a person prefers to stay at home but needs ongoing care that cannot easily or effectively be provided solely by family and friends. More and more older people electing to live independent, non-institutionalized, lives are receiving home care services as their physical capabilities diminish. Younger adults who are disabled or recuperating from acute illness are also choosing home care whenever possible. Chronically ill infants and children are receiving sophisticated medical treatment in home environments. Adults and

children diagnosed with terminal illness also are being cared for at home, receiving compassion and maintaining dignity at the end of life.

In-home and Community Support Services include the following:

A. Adult Day Services (ADS)

Adult day service programs provide help with activities of daily living (ADLs), instrumental activities of daily living (IADLs), therapeutic activities, and supervision for consumers during set daytime or nighttime hours. In some cases, these programs may also provide health monitoring and personal care services. If the program is housed in a residential care facility or nursing facility, the residents of the facility may participate in joint activities with the participants of the adult day service.

B. Home Health Care

Home Health Care is the in-home provision of services aimed at restoring or maintaining an individual's independent functioning.

Home health services include:

- i. Professional nursing services on a part-time or intermittent basis
- ii. Physical and/or occupational therapy
- iii. Speech pathology
- iv. Medical social work
- v. Nutritionist services
- vi. Services of licensed practical nurses, home health aides, and/or certified nurse assistants providing treatment and rehabilitation for illness or disability on a part-time or intermittent basis.

Individuals requiring skilled home care services usually receive their care from a Medicare-certified home health agency. Some agencies deliver a variety of home care services through physicians, nurses, therapists, social workers, home health aides, and volunteers. For cases in which an individual requires care from more than one specialist, home health agencies coordinate the care-giving team that provides services to meet the needs of the individual.

Some of this care is funded through Medicare, but most often it is paid for by MaineCare, private insurance, or the individual. Home health agencies or providers are required to be licensed by the State.

C. Hospice Care

Hospice care involves an interdisciplinary team of skilled professionals and volunteers who provide comprehensive medical, psychological, and spiritual care for the terminally ill as well as support for their families. Hospice care includes the provision of

related medications, medical supplies, and equipment. It is based primarily in the home enabling families to remain together. Trained hospice professionals are available to assist the family in caring for the consumer, ensure that the consumer's wishes are honored, and keep the consumer comfortable and free from pain.

In order to receive hospice care, a consumer must have six months or less to live. The consumer cannot receive any active treatment. Only palliative care is allowed.

D. Personal Support Specialist (PSS) Services

Personal Support Specialist Services are services provided by a Personal Support Specialist (PSS). These services are often required by an adult with long-term care needs to achieve greater physical independence:

- i. Bed Mobility: How the person moves to and from lying position, turns side to side, and positions body while in bed.
- ii. Transfer: How the person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet).
- iii. Locomotion: How the person moves between locations, within the room and other areas. If the person is in a wheelchair, self-sufficiency once in the chair.
- iv. Eating: How the person eats and drinks (regardless of skill).
- v. Toilet Use: How the person uses the toilet room (or commode, bedpan, urinal). Transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.
- vi. Bathing: How the person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (excluding washing of back and hair).
- vii. Dressing: How the person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.
- viii. Instrumental activities of daily living such as meal preparation, telephone use, etc.

E. Homemaker Services

Homemaker agencies employ homemakers and companions who support individuals with general housework, money management, meal preparation, grocery shopping, laundry, and incidental personal hygiene and dressing. Personnel are assigned according to the needs and wishes of each individual. Homemaker agencies recruit, train, and supervise their personnel and thus are responsible for the services provided.

F. Respite Care

Respite Care services are provided to individuals on a short-term basis because of the absence of **or** need for relief of the caregiver.

These services may be provided at home, in a licensed Adult Day Program, or in an institutional setting (e.g., an assisted living or nursing facility).

Regulating Health Care and Human Services

Health care and human services are licensed, regulated, and overseen by several state government departments and bureaus. In many cases, these state agencies have overlapping responsibilities.

1. **The Maine Department of Human Services (DHS)** offers a broad range of programs and services. With regional offices throughout the state, the agency provides direct social-worker support, acts as a source of funds, establishes consumer eligibility for programs, formulates policy, and licenses certain health care and human service workers.



- A. Within DHS, the **Bureau of Medical Services (BMS)** administers MaineCare programs.



BMS:

- i. purchases cost effective, accessible, quality health and social services for low-income people.
 - ii. protects the health and welfare of people needing hospital, nursing facility, and home health care services.
 - iii. assists consumers in utilizing the health care delivery system appropriately.

- B. Also within DHS, the **Bureau of Elder and Adult Services (BEAS)** promotes optimal independence for older adults and adults with disabilities. Through contracts with five Area Agencies on Aging and other community providers, the Bureau serves more than 40,000 older and disabled adults annually.

BEAS:

- i. operates **Adult Protective Services (APS)**, which provides or arranges for services to protect incapacitated and dependent adults (age 18 and over) in danger of abuse, neglect, or exploitation. APS investigates allegations of abuse, neglect or exploitation of adults age 18 and older; provides protective services, petitions Probate Court to become public guardian or conservator for incapacitated individuals who cannot direct their own affairs; manages assets of public wards; and develops specialized housing and other services.

- ii. oversees home and community-based care. It manages programs involving home health and other supportive services to 4,100 elderly and disabled adults in order to avoid or delay nursing home placement. Programs include: Home Based Care; Assisted Housing Programs; Alzheimer's Respite; Adult Day Care; Homemaker Services and the Long-term Care Ombudsman Program. It manages statewide pre-admission assessment of all nursing facility and home care applicants through a contract with Goold Health Systems.
- iii. works cooperatively with the Long-Term Care Ombudsman to investigate possible violations of rights of older adults and other persons over 18 years of age.
- iv. regulates/licenses assisted living, residential care programs, and adult day care programs in the state through the Assisted Living Unit,. The Assisted Living Unit establishes operational guidelines, inspects facilities for compliance, supports training and development initiatives, reviews funding and expenditures in facilities, and investigates situations where consumer welfare may be compromised. DHS contracts with Goold to assess people for their medical eligibility for residential care. This is done prior to admission and at regular intervals thereafter.
- v. provides home delivered meals, outreach, information and assistance, transportation, employment, volunteer, public education and legal services to 42,000 people annually through the five Area Agencies on Aging and Legal Services for the Elderly, Inc.

2. **The Maine Behavioral and Developmental Services (BDS)**

provides program mandates and funding to community providers of services to people with mental illness, mental retardation, and substance abuse issues. The Department funds a statewide network of mental health crisis intervention services and operates two state mental health facilities (Augusta Mental Health Institute and Bangor Mental Health Institute).



The Department's mission is to join with individuals, families, and communities to encourage and assist people with developmental disabilities, mental health disorders, and substance abuse disorders to achieve good health and meaningful living. Most of the services available are provided through regional offices or local agencies.

A. The **Department of Mental Health** exists to enhance the lives of people living with mental illness.

B. **Mental Retardation (MR) Services** provides support to adults with mental retardation and/or autism and their families. The MR

Services staff is responsible for coordinating a network of direct and contracted services in Maine.

- C. The Maine **Office of Substance Abuse** is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services.

The Office provides leadership in substance abuse prevention, intervention, and treatment. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

Paying for Health Care and Human Services

Who pays for health care and human services? With increasing numbers of older and disabled adults, rising costs in health care, and fewer family members to provide home care, this question is a major national concern.



While many persons are cared for at home by family members, many others use care paid for by state and federal funds. The majority of persons in nursing homes and assisted living facilities in Maine have their care paid for by MaineCare, the state health program for low-income persons.

1. Medicare

Medicare is actually two programs: **Part A** covers hospital and related care; and **Part B** covers physicians and other medical expenses. It was established by Title XVIII of the Social Security Act and is sometimes referred to as "Title XVIII." Medicare is administered by a number of agencies. The Social Security Administration handles eligibility determinations. The Centers for Medicare and Medicaid Services (CMS) governs administration of the programs, and private insurance companies under contract with the government handle the claims and payments.

Medicare pays for short-term, post acute nursing home care and home health care for persons who meet strict eligibility requirements.

2. MaineCare (Medicaid)

Medicaid is a federal medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 and is often referred to as "TITLE XIX." It is a joint Federal and State Program that reimburses providers for covered services to eligible persons.

The Medicaid program in Maine is called **MaineCare**. The Maine Department of Human Services (DHS) administers the program through the Centers for Medicare and Medicaid Services. CMS establishes general guidelines and monitors operation of the program by the states. Both state and federal funds are used in the program based on a percentage determined by each state's per capita income. States are given some flexibility in deciding what services are covered and who is eligible, so there are differences in Medicaid from state to state.

3. **Veteran's Affairs (VA)**

The VA-Paid Community Nursing Home Care Program is a plan under which the VA will pay for up to six months of nursing home care following hospitalization for those veterans who qualify.



If the veteran continues to require nursing home care, the veteran may remain in the nursing home for an additional period of time at the veteran's own expense. If the veteran does not have sufficient funds and is not eligible under Medicare, the state may be able to supplement the cost of nursing home care.

4. **Private Long Term Care Insurance (Third Party Payers)**

Some people have private long-term care insurance. As the demand for long-term care services increases, insurance companies have begun to develop policies that provide coverage for nursing home and/or home health care. These policies are expected to account for an increasing percentage of long-term care financing, although most experts agree that they will never represent a major source of payment.

Private Insurance companies are known as **third party payers**.

5. **State Funded Programs**

In some cases, the state of Maine will pay for home care, adult day care, homemaker, and some assisted living services using state funds for individuals who do not qualify for MaineCare and do not have sufficient resources to pay privately for care.

6. **Private Pay**

If an individual has sufficient assets, he or she will be expected to pay for their nursing home care with personal funds until the money and assets (other than those funds excluded by law) runs out. Paying with personal funds is known as **private pay**.

Some facilities admit only private pay consumers, others take a mix of private pay and state assisted consumers, and some are often entirely occupied by people who are state-assisted.

Important Values in Health Care and Human Services

Before we talk about more of the specifics of doing your job, we need to take time to talk about the values behind the work that we do. If your mother, your grandfather, or your child, were in a hospital, nursing facility, residential facility, or cared for in their home how would you want them to be treated?

The easiest way to sum up the values associated with health care and human services is the **Golden Rule**.



NOTE: As a human-service employee, you should always remember the **Golden Rule** - “**Do to others, as you would like them to do to you.**” In other words, you should always treat your consumers the same way you would like to be treated if you were in the same situation.

Regardless of where you work in the human service field (a hospital, nursing home, residential care facility, or somebody’s home), there are important specific values that underlie the work that you do:

1. Choices

One of the ways that people gain control over their lives is to have choices about what they do, who they spend time with, where they go, and what they eat. Moving into a nursing or residential care facility or using home care does not remove a person’s right to choose. The person should still make all the decisions or choices that he/she is able to make. Sometimes staff members think that a consumer is not making a “good” choice. It may not be the choice that staff members would make, however, *it is the right of the person to make that choice*. In addition, *it is your job to support that choice* – regardless of whether you agree with the decision or not – *unless*, the consequences of the choice would be dangerous for the individual.

Some individuals have been making their own choices all of their lives and would resent having staff members take over for them. Other individuals have never really had the chance to make choices. They may have lived in institutions or been in families where other people made all of the choices. They may need help in learning how to make choices on their own. The

ultimate goal is for you to be respectful of the consumer choice while not allowing the consumers to endanger themselves.

2. Person-Centered

When you focus on the needs and interests of the people in the facility or home environment, you are being person-centered. If you want to know what a person wants to do, *ask her*. If you want to know what a person thinks of what you are doing, you should *ask him*. In order to really be person-centered at work, you need to listen to what people are telling you. Some people may not be able to use words to talk to you, but they can tell you what they think and feel by their actions.

3. Consumer Involvement in Planning

People need to know what is going to be happening in the next few hours, the next day, and the next week. Involvement in planning helps people to feel like they have a future to look forward to. It allows the person to have a sense of control over his/her own life. It is also a way to help staff focus on the work that is most important and to prioritize accordingly. *Planning is a way to organize and to reduce the number of surprises for both the staff and the consumers.*

4. Independence

People need help in certain areas of their lives. This does not mean that they need to have someone doing *everything* for them. It is important that people do as much for themselves as they can for as long as they can. For some people, this will mean learning new skills to become more independent than they were before. For others, this will mean keeping their current skills for as long as they can. It may not seem very efficient at times, but having a person get his own cup of coffee for as long as he is able to is highly desirable. Promoting independence by teaching new skills or encouraging people to use the skills they already have is one of the important roles of staff in all work environments.

5. Participation in the Community

Each of us is a member of many communities. We live in a place that is called a community (e.g., a neighborhood, city, or town). We also live and work among groups of people at work, the church or synagogue, a quilting group, or a sportsman's club, which are also called communities. Each of these different types of communities (where we live and the groups we are a part of) helps to describe who we are and how we are connected to other people.

People who live in nursing homes, residential facilities, or even in their own home need to be participating members of their community. At a minimum, they need to be a part of what is going on in their immediate

environment (e.g., events at the facility or home they are living in). They may also want to go to church, to volunteer as a reader in the elementary school, to participate in a fundraiser, to join a ceramics group, or to go to a garden club. As a direct service staff member, you may be asked to provide a range of services to assist individuals in maintaining their involvement. You may need to arrange transportation, assist the person to get ready, or even accompany the person to his/her event. By doing this, you will be promoting their participation in the different communities.

People in nursing facilities, residential facilities, or a home need to have people in their lives that are not paid to spend time with them. By participating in activities (with groups and communities) outside of their residence, consumers are more likely to have regular contact with people who are not staff.

6. **Being Positive**

Your attitude at work will make a huge difference for the people with whom you work. Consumers look to you for signals about how they are doing and how they should feel. If you are positive and upbeat with them, they are more likely to feel encouraged. If you are rushed, discouraged, or frustrated, those attitudes will spill over onto the consumers.

7. **Individuality**

Each person you work with is an individual (a unique person) and should be treated as such. An individual may have the same diagnosis as somebody else, but she will not have the same life experience, the same family, the same personality, the same successes, and the same barriers. It is important to always keep this in mind. You should know the individuals you work with well enough so that you can see them for who they were, who they are, and who they can be.



Career Opportunities in the Health Care and Human Service Fields

There are many career opportunities in the health care and human services fields. These jobs offer not only competitive wages (often with benefits), but also the opportunity make a real difference in people's lives.

A number of entry-level positions are available in health care and human services, and they require no previous health care or human service

experience. Each of these positions offers the opportunity to advance to more senior positions, as your training and experience grows:

1. Homemaker

Homemakers assist individuals with household or personal care activities that improve or maintain adequate well being. A homemaker's responsibilities can include household tasks such as grocery shopping, errands, light housekeeping, laundry, and meal preparation. Typically, these positions require a High School diploma.

2. Personal Support Specialist (PSS) - formerly Residential Care Specialist (RCS) and Personal Care Attendant (PCA)

Personal Support Specialists help older, disabled, and mentally ill persons in their homes. In some cases, this might be a level II Assisted Living Facility (i.e., a facility with seven or more residents). In other cases, it might be the person's own home. Most Personal Support Specialists work with older or disabled people who need more extensive care than family or friends can provide. Some PSS staff members work with families in which a parent is incapacitated and small children need care. Others help discharged hospital consumers who have relatively short-term needs. PSS's help people with bathing, transfer, ambulation, dressing, cooking, shopping, cleaning, and other activities of daily living and instrumental activities of daily living.

Personal Support Specialist must complete a DHS approved training course. The exception is PSS staff members where the consumer self-directs (controls) his or her own care. In these cases, the consumer is responsible for training the PSS.

3. Certified Residential Medication Aide (CRMA)

Certified Residential Medication Aides work in numerous residential settings. They are trained to administer medications safely and accurately.

4. Mental Health Rehabilitation Technician (MHRT)

Mental Health Rehabilitation Technicians typically work in Residential Care Facilities serving adults with mental illness. They must complete training that includes training in first aid, CPR, behavioral intervention, and medication administration.

5. Certified Nursing Assistant (CNA)

Under the supervision of Registered nurses, Certified Nursing Assistants provide much of the daily, hands-on care needed by people in hospitals, and nursing facilities. They help people in and out of bed and assist with dressing, bathing, and eating. Because they work

with people on a daily basis, nursing assistants can develop personal relationships with the consumers. Expressing compassion and developing friendships are integral parts of the job. For many, a nursing assistant position is the beginning of a career ladder, and they will continue their education through Licensed Practical Nurse and Registered Nurse preparation.

All nursing assistants are required to be certified and listed on the CNA registry. This means completing at least 150 hours of training and passing a certifying examination. Some adult education agencies offer CNA training, as do some career and technical schools and community colleges.



NOTE: Some of the hours that you spend attending the PSS program can be applied toward the CNA training program, but you must start the CNA training within two years.

6. Certified Nurses Assistant – Medications (CNA-M)

CNA-Ms are experienced Certified Nursing Assistants that administer selected manageable medications to consumers who are four years of age and older. Additional training is required. This complex nursing task is performed under the direct on-site supervision of a licensed nurse only in long term care, state mental institutions, county jails, state correctional facilities, and assisted living settings. CNA-Ms must pass a 120-hour medication course approved by the Maine State Board of Nursing.

7. Home Health Aide (HHA)

Home Health Aides work for Medicare certified home health agencies. They help older, disabled, and medically ill persons to live in their own homes instead of in a hospital or other health care facility. Home Health Aides perform simple medical checks such as pulse, temperature, and respiration; help with simple prescribed exercises; and assist with medication routines. They may provide housekeeping services, personal care, and emotional support. Some accompany people outside the home, serving as a guide, companion, and aide.

Home Health Aides work in people's homes as part of a health care team that may include nurses; physicians; physical, occupational, and speech therapists; dietitians; and social workers.

Home Health Aides must complete a 150-hour CNA course along with sixteen hours of extra training.

Working in a hospital, nursing facility, assisted living facility, or an individual's home can be a rewarding career. But whether this is just a job or a real career will depend upon you and how you plan for your future. It's useful to think about the kind of work you want to do in health care or human services, the types of environments you might prefer to work in, and how you would like to advance both in terms of authority and pay.

Other Staff in Health Care and Human Services

Staff members in the different types of nursing and assisted living facilities are often assigned to specific departments, e.g., nursing, housekeeping, dietary, etc. Each department is responsible for contributing to the overall functioning of the facility. The size and composition of departments of each facility depend upon its total size and the level of care provided. Therefore, there may be significant differences among facilities. Some larger facilities may have staff with defined responsibilities. Smaller residential care homes may only have one or two staff members.

Examples of typical staff and departments include:

1. **Dietary Department**

The dietary department is responsible for planning and preparing the food served in accordance with state licensing regulations, using a menu cycle, such as a four-week cycle or a seasonal cycle. A physician must order special diets.

Examples of dietary staff include:

Dietician -- expert in planning menus, diets, and dietary procedures. The dietician is responsible for setting up special diets, as well as maintaining proper nutritional levels for Consumers.

Food Services Supervisor -- is responsible for the daily preparation of foods, special diets, etc. He/she uses the menus developed by the dietician.

Diet Aid -- sets up and delivers trays.

Porter -- Cleans dining area and does dishes.

2. **Activities Department**

Many facilities have an activities program. Activities should be planned to meet the needs and interests of the Consumers and to enhance the quality of life.

Examples of activity staff:

Certified Therapeutic Recreation Specialist (requires a BS degree) – Provides treatment services to improve functional abilities, enable independence, and promote healthy leisure lifestyles.

Activities Coordinator - requires a 200-hour course – responsible for developing, scheduling, and conducting programs to meet the social and recreational needs of Consumers.

3. Nursing Services

The nursing department generally includes Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs).

Examples of the nursing staff:

The Director of Nursing (DON) is a registered nurse (RN) who is accountable for the nursing care provided to consumers by the entire nursing staff - including nursing supervisors, licensed practical nurses, and certified nursing assistants. The Director of Nursing is responsible for ensuring the delivery of safe consumer care according to current nursing standards of practice.

The Charge Nurse is responsible for nursing care on a floor or in an area or section of the nursing facility during a particular shift. This person may be a RN or a LPN under the direction of a RN.

Licensed Practical Nurses (LPN) are nurses who have completed one year of vocational training in nursing. They may be in charge of nursing on a particular shift under the direction of an RN. LPNs can administer medications and perform treatments under the direction of an RN.

Registered Professional Nurses (RN) – constitute the largest group among all the health occupations. There are four major educational paths to registered nursing: associate degree in nursing (A.D.N.), Bachelor of Science degree in nursing (B.S.N.), Master of Science degree in nursing (M.S.N.), and diploma. Staff nurses provide bedside nursing care, carry out medical regimens, and sometimes make home visits. RNs supervise licensed practical nurses and nursing assistants.

Certified Nursing Assistants (CNAs) – See description above.

Certified Nursing Assistants – Medications (CNA-M's) – See description above.

Home Health Aide - See description above.

4. **Administration**

The administrative unit of a facility or nursing home may include the nursing home administrator, secretarial staff, accounting, and admissions staff.

Examples of administrative staff:

The Chief Executive Officer (CEO) or Administrator is responsible for overall (fiscal, legal, medical, and social) management and operation of the facility, organization, or home health agency. This individual is ultimately responsible for what happens in the agency.

5. **Social Services**

Social Services departments are responsible for identifying the social and emotional needs of the consumer. An assessment of each consumer's needs should be found in his/her record and needed services should be incorporated into the care plan. Every nursing facility with more than 120 beds is required to employ a full-time professional social worker.

Examples of Social Services staff:

Social worker -- person trained to identify socially related and emotional needs of consumers and provide services necessary to meet such needs.

6. **Housekeeping and Laundry**

Members of the housekeeping staff are usually responsible for basic housekeeping chores such as sweeping floors, dusting, emptying waste cans, and cleaning furnishings.

Every nursing facility has laundry facilities and is responsible for providing clean bed linens and towels. Many Assisted Living Facilities are also equipped to launder consumer clothing.

7. **Clinical Staff**

Medical staff members are responsible for attending to the medical needs of the consumers.

Examples of these positions are:

Medical Director -- the physician who formulates and directs overall policy for medical care in a hospital or nursing facility.

Attending Physician -- directly responsible for the medical care of individual consumers or consumers. Each consumer/consumer must

either choose a physician or have one assigned by the hospital or nursing facility to oversee all of the medical care.

Podiatrist -- specializes in the diagnosis and treatment of diseases, defects, and injuries of the foot.

Dermatologist -- specializes in the diagnosis and treatment of diseases, defects, and injuries of the skin.

Ophthalmologist -- specializes in the diagnosis and treatment of diseases, defects, and injuries of the eye.

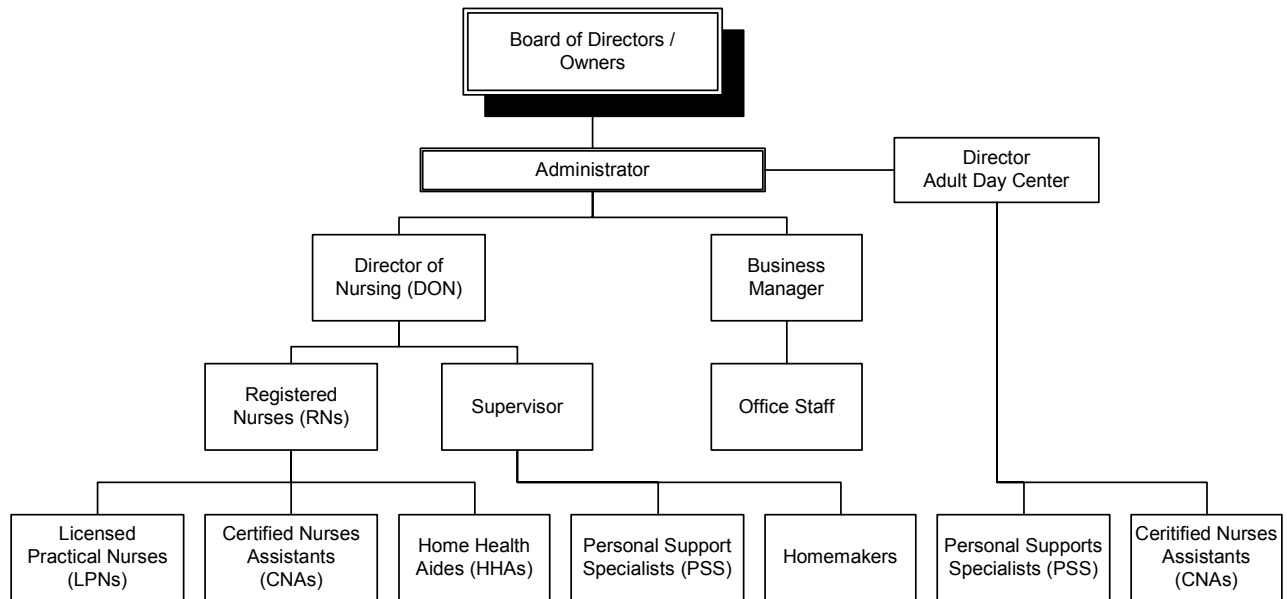
Physical Therapist (PT) -- trained in restoring the function of muscles in arms, legs, backs, hands, feet, etc., through movement, exercises, or treatment. A Physical therapist may be a consultant to the facility- rather than a full time employee. Sometimes there are Physical Therapy Assistants (PTAs) who carry out the plans of the physical therapist.

Occupational Therapist (OT) -- While the physical therapist is concerned with restoring the function of muscles, the occupation therapist is concerned with developing self-care skills such as dressing, bathing, and meal preparation.

Speech and Language Pathologist – Speech and Language pathologists plan and administer speech-language therapy treatment for consumers experiencing speech, language, and auditory problems. They counsel consumers, families, or other caregivers about disorders and the resultant problems they can cause. They may also assist consumers in developing new ways to swallow or speak (e.g., stroke victims and children with developmental delays).

Since all employees cannot directly report to the CEO or Administrator (especially in larger organizations), the facility will have a chain of command shown in a document called the “organizational chart”. The chart tells you who reports to whom. It tells you where you fit in. It allows you to know whom you report to and whom (if anyone) you supervise. A sample chart is shown on the next page. Remember - the agency or facility you work for may be organized in a different way. Know who your supervisor is and whom you should report to with problems and concerns.

Sample Organizational Chart: Saco River Services and Adult Day Center



You will note that the chart does not contain names – only titles. For example, Mary may be the name of the CEO or Administrator, but the chart only lists the title “CEO or Administrator.” In this way, the chart does not have to be changed as people are hired or leave. It is important for you to know where you fit in. If you know this information, you know whom you should go to with concerns, questions, or problems.

When you look at the various roles or jobs on the organizational chart, you will realize that you are part of a team. The team’s overall job is to provide services to the people in the hospital, facility, or home.

2

Module 2: Basic Work Skills and Job Maintenance



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Describe your responsibilities as a health care and human service worker;
- ➔ Describe your rights as an employee in the State of Maine;
- ➔ Identify good work habits such as punctuality, reliability and integrity;
- ➔ Describe conduct that is appropriate in a work setting;
- ➔ Explain why prioritizing is important;
- ➔ Prioritize a list of common tasks;
- ➔ Describe the importance of proper boundaries when working in health care or human services;
- ➔ Explain the importance of personal appearance, hygiene, nutrition, and personal stress reduction for effective job performance; and
- ➔ Explain the importance of personal and career development.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Responsibilities
- Rights
- Prioritize
- Teamwork
- Boundaries
- Burnout

Rights and Responsibilities

Health care and human service workers have certain broad responsibilities while delivering daily services. Staff members also have certain rights that protect their interests during employment. As a service provider, you are subject to the same state and federal laws as any other person. You are also entitled to protections provided by state and federal law.

It is important when carrying out a task as a staff member that you think about its appropriateness. Is the behavior legally permissible? Does it interfere with an individual's right to privacy? Confidentiality? Safety? Non-discrimination? Freedom from abuse? Continuity of services? You protect yourself and the consumer by carrying out *only* those acts that are permissible and appropriate under law. Your responsibilities and your rights as an employee are summarized on the following pages:

1. Your Responsibilities

A responsibility is defined as an obligation. It is something you are expected to do. For example, all team members are expected to obey state law. You may not perform any illegal act. You may not do something illegal even if ordered to do so by your boss.

A. You are responsible for reporting any signs or suspicions of physical or psychological abuse, neglect, or exploitation of children and vulnerable adults. This responsibility will be discussed in more detail later in the course.



NOTE: *Never* allow yourself to become involved in any acts that cause neglect, abuse, or exploitation of any kind to a consumer. Report such acts immediately. Under state law, you may do so without your identity being revealed.

B. You are responsible under federal law and state regulations to treat any information about a consumer as confidential. Thus, you may not reveal the contents of interviews, conversations, service-planning sessions, any written records, service notations, correspondence, and other documents – UNLESS it is work-related and you are talking with your coworkers or supervisor. Aside from routine staff use, such materials may not be revealed to anyone [except state officials] without the consumer's written permission.



NOTE: It is your obligation as a staff member to see to it that confidentiality of consumer information is maintained.

C. **You are responsible** for carrying out reasonable and proper orders received from your administrator, nursing supervisor, resident care director, or supervisor. This should be done in a timely and professional manner so that consumers obtain the best benefit from your efforts. This includes all the tasks outlined in your job description as well as any policies and procedures of the facility or agency that you work for.

D. **You are responsible** for respecting consumer rights. These rights are outlined in Federal and state law. It is your job to know these rights and see that you respect them in your daily work. The issue of rights will be covered more completely in another session of this course.

2. **Your Rights**

Rights are privileges or powers that we are entitled to as employees.

A. **You have a right** to decent working conditions, fair treatment, and regular access to training and other activities that support your work. Discrimination is not permitted.

B. **You have a right** to the same protections provided to other types of workers throughout the State of Maine. There are a large number of state and federal laws that govern workers and their environment. It would be impossible to include all of them here. However, listed below are a few of the laws which apply to workers:

OSHA: federal law, which governs the workplace of workers to assure safety. They require protective equipment and training in certain situations.

Wage and Hour: law, which regulates number of breaks an employee may have, overtime and other matters relating to employee pay and rest periods.

Hazardous Chemical: law requires that employees know about the chemicals they work with, as well as hazards of those chemicals and the need for protective gear.

Fair Labor Standards: federal law which dictates work hours, overtime pay, minimum wage, and anti discrimination practices.

Workers Compensation: law that protects workers when injured at work by providing medical and other benefits.

Below are some of the rights, which you have as an employee in the State of Maine: You have a right to:

- A. a safe work environment;
- B. clear supervisory support and direction in your work;
- C. work-related training at least annually in areas related to the needs of the consumers;
- D. refuse to carry out illegal acts;
- E. report any suspicion of abuse, neglect or exploitation of a person without reprisal from your employer – as long as it is done in good faith;
- F. have a job description;
- G. a performance evaluation (completed by a supervisor periodically); and
- H. fair treatment with no discrimination.

You should be fully informed about your responsibilities and your rights as a CNA or PSS. Take time to become familiar with these responsibilities and rights. Your responsibilities do not go away simply because you did not take the time to learn them. As the old saying goes: "Ignorance of the law is no excuse." Similarly, your rights cannot be protected unless you learn about and know what they are.

Good Work Habits

To be successful in any career path, it is important to practice good work habits:

1. **Be punctual/come to work on time.** When you are late for work, it shows a lack of responsibility and a lack of commitment to your job. It also may place an unfair burden on your coworkers who must cover your workload until you arrive and the consumer(s) who may not be able to function without your help.
2. **Be dependable.** Your employer, coworkers, and consumers depend on you to be there as part of the team.

3. **Be reliable.** Your supervisor, coworkers, and the consumers you serve should be able to count on you to do what you say you are going to do.
4. **Dress appropriately for your job.** Like it or not, the way you dress makes an impression on the people you are working with. Ripped jeans, faded t-shirts, wrinkled or dirty clothes, and messy hair all create an image that can be worrisome to families and consumers. Some facilities and agencies have dress codes for their employees. You should know what your employer's standards are about dress.
5. **Act appropriately.** Don't bring your own problems to work and refrain from gossiping. The consumers have enough to worry about without the added burden of your problems and complaints.
6. **Maintain proper hygiene and appearance.** As a health care and human service worker, you serve as a role model.
7. **Maintain a positive attitude.** The attitude you bring to work can have a significant impact on the consumers and your work environment.
8. **Act with Integrity.** Make sure you fulfill the promises that you make to your coworkers and the people you serve.

Work-Related Skills

Health care and human service environments are busy places with many different demands made on staff all at once. Most people have many needs, preferences, and requests. You will find that sometimes there is more to be done than time allows. This should not lead to situations where important things do not get done before things that are not important. When the staff does not make distinctions between things that are *urgent*, *important*, and merely *routine*, duties may not be carried out satisfactorily, or at all. The urgent and important tasks should always be done first.

1. Prioritizing

The term "prioritization" means listing jobs or tasks in the order of importance. It's vital that staff **prioritize** their duties, so that consumers are served in a timely fashion according to their needs. Thus, highly urgent tasks or services are completed first, or as needed, with those that are less urgent are carried out second.

Prioritizing does not mean doing only those tasks that are urgent or "emergencies" but simply doing them first, completing them, and then moving on to less demanding tasks. All assigned tasks need to be done in a

typical workday. It's just a matter of getting them in some appropriate order on a daily basis.

Some of the questions that you should ask yourself when setting priorities are:

- A. Does the task involve a safety issue? In other words, does the task involve something that is life threatening or potentially life threatening?
- B. Does it affect the consumer?
- C. How many people are affected by this task?
- D. Is it a staff need?
- E. Is it a sanitation issue?

As an example, let's say that you are asked to complete the following tasks:

- A. Help John to get dressed
- B. Clean the staff lounge
- C. Clean the bathroom
- D. Take Mark to the doctor at 10:00 A.M.

You are working from 7:00 A.M. – 2:00 P.M. Which of these is most important? How would you organize the tasks?

John cannot go out until he is dressed. It is unsafe for him to walk around without shoes – he may fall. Therefore, assisting John would be first on the schedule. Mark's appointment is set for 10 A.M. You cannot do that at another time. Washing the bathroom affects the health and safety of consumers and staff. Cleaning the staff lounge is important to staff but not to consumers.

Thus, the priority order of these particular tasks would be:

- | | |
|---------------------|----------------------------|
| 7:00 AM – 8:00 AM | – Help John to get dressed |
| 8:00 AM – 9:00 AM | – Clean bathroom |
| 10:00AM – 11:00 AM | – Take Mark to the doctor |
| 11:00 AM – 12:00 PM | – Drive Mark home |
| 12:00 PM – 1:00 PM | – Lunchtime |
| 1:00 PM – 2:00 PM | – Clean the staff lounge |

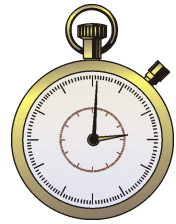


If you are not sure what your priorities should be – ask your supervisor for assistance. He/She can help you to decide what is most important.

Home Care – You may have to consult with the consumer in order to prioritize your visit to a home. The individual's priorities are very important when planning your time. Check to see if he/she has a list of activities for you to do after you arrive.

2. Time Management

You will find that you can get more done and feel less pushed if you practice *time management* each day. Time management involves planning your day and allocating your time according to the priorities. Many occasions where staff are rushed or overburdened could be prevented with more efficient *planning* of the workday and setting aside time to get things done.



3. Teamwork

Health care and human service work also requires teamwork. More can be accomplished when people work as part of a team than when they work as individuals. Discuss your tasks with a coworker or the person needing support and decide how you can work together to get the tasks done more efficiently. It takes a few minutes to do, but it may save you time later in your shift.

For instance, suppose Mary and Joan are working on the same unit in an assisted living facility. They meet at the start of their shift to discuss their assignments. Joan discovers that she needs to take Evelyn to the Optometrist to get new glasses. Mary has to take Sam to pick up his hearing aids. Both have to give nail care to everyone. They decide that Mary will do all the nail care and Joan will take Sam and Evelyn out in the community. More will get accomplished because no one will be waiting for the car or nail equipment. Mary and Joan do not have to change their plans for the other.

Two caregivers can come together to form a team or the whole facility can form a team. The benefit to the consumer is that more is accomplished and more needs are met.



NOTE: Prioritization of tasks and time management can help a team to work more efficiently. Resist the urge to do tasks randomly. Coordinate major tasks and interventions with other workers. Communicate with other workers who will be a part of your team.

Boundaries

Another key concept in health care and human services is the idea of **boundaries**. Boundaries are the limits or guidelines that define your relationships with other people both at work and in your personal life.

In order to maintain proper boundaries, you need to know what the limits are in your relationships with fellow workers and with consumers. There is a distinct difference between social and work relationships. In a social relationship, the two participants are peers or equals. There is give and take as well as compromise as they interact. In a work relationship, the two participants are often *not* of equal status.

In a work relationship, the caregiver may have the upper hand because of his/her position. Further, in work relationships, the focus is on the consumer or customer and not the staff. Hospital, nursing facility, assisted living, and home care staff members are there to assist, support, and facilitate the needs of the service consumers. In the process, bonds develop, friendships begin, and we connect. All of these processes are normal, even desirable. But you must be careful when these relationships occur between a staff member and a consumer.

It is important, for example, that you not overstep the limits of your assigned work role and take on the responsibilities of other staff. Be clear about what your job is. Don't overstep your authority. This does not mean you have to be rigid or inflexible with other people. You should communicate with the other team members when you think that you may be operating on their "turf" and clarify your roles and responsibilities at work from time to time.

As a health care and human service staff member, you must maintain proper boundaries with the consumers. In general, this means that there should be nothing that you would do for one consumer that you would not do for another. Otherwise, you may seem to be showing favoritism, partiality, or lack of objectivity when important decisions or actions are being made. Staff members who forget to maintain a proper working distance may unrealistically raise the expectations of consumers, or appear to other consumers to be unfairly generous with their time for a "favored" consumer friend. Such appearances seriously complicate interactions between consumers and all staff. Examples of improper working boundaries are: taking the consumer to your house for the weekend, buying gifts for the consumer, helping the consumer write a will, and taking money from the consumer.

Boundaries In Community and Home-Based Care

Boundaries in home care settings have special meaning. Boundaries in home care are often defined by the job description, the consumer's individualized

care plan, and legal ethical codes. Boundaries are in essence, the limits set for health care and human service staff members when they are performing activities for consumers in their homes.

Many of the work activities in a home are determined by the individual needs of the consumer - such as bathing, exercises, and meal preparation. Other work activities are determined by the funding source (who is paying the bill). For example, some state programs do not allow staff members to transport consumers. Other programs require that 60% of your time be spent on hands-on activities (personal care), as opposed to housework or errands. *All* programs limit care to the consumer. That is, you are not allowed to provide services to family members even if they live in the same house. This is why staff members focus on the consumer's needs (e.g., clean only the areas the consumer uses; wash only the consumer's clothes; transport only the consumer to appointments). Since many programs are supported by tax dollars and consumers are the ones in the home who are eligible, it is important that you target your activities to the consumer and not to other family members who may not be eligible for services.

The consumer's care plan takes into consideration the needs of the consumer as well as the expectations and restrictions of the funding source. Therefore, you are always served well by following this plan. If a consumer asks for tasks to be performed that are not on the care plan, you should call your supervisor. This gives your supervisor an opportunity to re-assess the consumer's needs and meet the guidelines/rules established by the current funding sources. Additions and changes can always be made to a consumer's care plan – as long as the proper process is followed.

Boundaries protect you in many ways. Through the job description, you know what you are expected to do for consumers as part of your job. Through the care plan, you know what each consumer needs for assistance. Through your understanding of what is legal and ethical, you can decide how to behave in a manner that is considerate of the consumer's needs and within legal limits.



NOTE: It is possible and desirable for you to act with warmth, support, kindness, and concern on the job, but it is important that you do so *from a working distance*. Consult with your supervisor to learn about your employer's policy about boundaries on the job.

Avoiding Excess Stress and Burnout

1. Stress

No job is free from stress. All work brings responsibilities, problems, demands, and pressures. In normal circumstances



stress is an unavoidable part of working life. We are paid to work and a reasonable amount of pressure must be expected.

However, our ability to deal with pressures is not limitless. When the pressure is excessive and unrelenting it can become harmful. Performance drops and your health declines. This is why it is important that you understand how this can happen and what you can do to prevent it. You don't want to remove all pressure from work, but you will want to understand and control the harmful levels of stress that may affect your performance on the job.

What is Stress?

Stress is usually described as a person's reaction to demands, pressures, and expectations. *Not all pressure is negative.* People often are motivated to perform at their best by the challenges and difficulties (i.e., stress) in their lives.

Most people are accustomed to minor signs and symptoms that indicate when they are stressed or "up-tight". Generally, these symptoms last only briefly and have little or no long-term effect. Occasionally, however,

The effects of excessive stress can be both physical and psychological:

- A. **Physical effects** are increased heart rate, headache, blurred vision, perspiring, dizziness, aching neck and shoulder muscles, clenched jaw, and skin rashes.
- B. **Behavioral effects** include increased anxiety and irritability, "flying off the handle" easily, excess consumption of alcohol and other drugs, fitful sleeping, and poor concentration.

As you can see, each one of these signs could also apply to a range of other health problems. That is why it is important to consult with a trained professional if severe stress is suspected.

When relief from a stressful state is not available, or is of short duration before the next onslaught, the body has no time to repair and the stress becomes long lasting and more serious. Long-term problems emerge and recovery time, even with professional help, takes much longer.

2. Burnout

Research has shown that people working in the helping careers are especially at risk for burnout, particularly when they are in direct service roles. Why? Because those drawn to helping careers care about what happens to real, live fellow human beings. We want what is good, right, just, best, and productive for them, and we tend to take on personal responsibility to ensure that this happens.

Why should you be concerned about burnout? Because depending on your role, you must be a responsible and dependable caregiver for those you serve.

What is Burnout?

At its root, burnout is a state of psychological and physical exhaustion: the staff member is emotionally worn out and has nothing left to give others. He is physically worn out and does not have the energy or stamina to support those who need him.

Signs of Burnout

You must remain alert to the signs of “burnout.” What are the primary signs? For the most part, they are similar to those of depression.

Emotional Cues:

- A. Emotional exhaustion
- B. Low energy level, but sometimes an increase in physical activity level (agitation, driven, can't slow the motor down)
- C. Fatigue
- D. Irritability
- E. Difficulty thinking or concentrating on tasks at hand
- F. Loss of interest or pleasure in things usually enjoyed
- G. Depersonalization of the people in need of support.

Biological Cues:

- A. Sleep disturbances (sleeping too little or sleeping too much)
- B. Appetite disturbances (could be loss of appetite or overeating)
- C. Weight changes (could be loss or gain)
- D. Mood swings (e.g., getting sad at night when not occupied with other things)
- E. Loss of interest in sexual activity
- F. Increased vulnerability to infections and colds
- G. Deterioration in general health.

Other Cues:

- A. Reduced sense of accomplishment (“what I do makes no difference”)
- B. Feelings of worthlessness
- C. Feelings of guilt.



NOTE: The time to address burnout is before it occurs, or, at least at its earliest signs. Learn to recognize the events/situations that are stressful to you – then work to avoid them, eliminate them, or reduce their intensity.

3. Managing Stress and Avoiding Burnout

- A. Take care of your own emotional and physical well being first. This is not selfish! You cannot do you best for anyone else unless you are in good shape yourself. Here are some tips:
 - i. Exercise three to four times per week (walking, jogging, swimming, etc.)
 - ii. Eat well-balanced, nutritious meals
 - iii. Avoid caffeine, nicotine, and other stimulants, as these will only heighten stress
 - iv. Get plenty of sleep.
- B. Leave your work at work; don't take it home with you. Make a clear distinction between your work life and your personal life: neither should get in the way of the other.
- C. Do not take on all of the problems of your consumers. You must use yourself as a purposeful change agent, but you can't do it unless you maintain an appropriate professional distance.
- D. Maintain and nurture your social supports on and off the job. Do not allow yourself to become isolated. On the job, talk with colleagues who share and understand what you are experiencing and feeling. Off the job, maintain contact with family and friends, partly because they do not share your on the job experiences. Otherwise, you'll be talking about work when you are not at work and that's taking your work home with you. Your life must be a balance of work, love, pleasure, and recreation. Maintain supportive relationships in all aspects of your life.

Make sure that you leave time in your life to "play," because this is a major way of recharging your batteries. Part of this is just having fun, but part of it is taking vacation, using personal days when you need them, and using sick days when you are truly sick. You cannot do your best work if you are not rested, have not taken care of things important in your own life, and are not feeling well. Keeping both body and mind in good health is an important way of managing stress and avoiding burnout.

Personal and Career Development

Another way to improve your work performance is to take advantage of further education. Education will allow you to adjust your care giving to newer ideas and ways of doing things. This will benefit you and the people you are working with. In many cases, you will be required under state regulations to have additional training each year.

You may also be interested in other sources of professional education, such as programs offered by the University of Maine System, the Maine Technical College System, or on the Internet through distance learning. Further training will enable you to take advantage of a wider variety of job opportunities. This course is meant only as an introduction to health care and human service concepts. ***Plan to go beyond initial training for your own benefit.***

Senior positions will increasingly demand further training. As state and national standards are raised, educational standards for work in this field will also increase. Part of career planning is setting educational goals that will help you create the kind of working future you most desire. Getting the right kind of experience is also worthwhile. The greater the breadth of your skill and knowledge, the more employable you become particularly in senior positions. Familiarize yourself with the industry, its major operators, types of facilities, and programs. It will be a great help to you as you pursue your career.

3

Module 3: Legal and Ethical Aspects of Care



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Describe key regulations governing the functioning of health care and human service providers;
- ➔ Explain basic consumer rights;
- ➔ Describe the legal status of consumers including guardianship, power-of-attorney, living wills, and “Do Not Resuscitate” (DNR) orders;
- ➔ Recognize signs and symptoms of abuse (verbal, physical, psychological, and sexual) as well as neglect and exploitation;
- ➔ Explain your responsibilities in reporting known or suspected abuse, neglect, or exploitation; and
- ➔ Explain what ethics means and how it applies in the health care and human service fields.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- | | | |
|------------------------|---|------------------------------------|
| • Regulations | • Durable Power of Attorney for Health Care | • Adult Protective Services |
| • Consumer Rights | • Living Will | • Long-term Care Ombudsman Program |
| • Incapacity | • Do Not Resuscitate Order | • Ethics |
| • Guardian | • Abuse | |
| • Ward | • Physical Abuse | |
| • Conservator | • Sexual Abuse | |
| • Fiduciary | • Neglect | |
| • Full Guardianship | • Exploitation | |
| • Limited Guardian | • Mandatory Reporting | |
| • Representative Payee | | |
| • Advance Directive | | |
| • Power of Attorney | | |

Regulations

As this course will stress repeatedly, health care and human services are regulated services in the state of Maine. If you are to be effective, you must become familiar with state rules governing the different types of covered services and abide by those rules while you work. These rules are called **regulations**, and they have the same importance as laws in the state. State regulations affect all aspects of care, and it's to your advantage to be familiar with how regulations matter in the work that you do. In the rest of this module, you will learn about some of the key laws and regulations affecting your work.

Regulations cover such areas as:

1. Administration and storage of medications.
2. Procedures for accessing psychosocial and medical services in the community.
3. Assessment and service planning.
4. Admissions policies and procedures.
5. Implementation of activities programs.
6. Hygiene and safety compliance.
7. Handicap access and related ADA issues.
8. Minimum staff qualifications.
9. Consumer records and tracking of services.
10. Number of persons that can be served in particular facilities.



NOTE: All employers must have a copy of the regulations on hand. All staff should be familiar with the regulations that apply to their specific work setting.

Consumer Rights

Sometimes people feel that in order to get help they must give up control over their life. This can make them feel more vulnerable and dependent. Some consumers may feel that the staff or family members have all the power and

that they must do what they are told to do. However, this is not the case in most situations.

Regardless of the services or help that people receive in health care and human services, *they do not lose the rights protected for all of us by the U.S. Constitution, the Bill of Rights, and other federal and state laws.* They have a right to make their *own* decisions about the services they receive.

This is so important that the Federal Government, State of Maine, and other organizations have specified rights that must be protected when someone receives care.

For example:

1. **A Consumer's Bill of Rights.** The American Hospital Association has developed "A consumer's Bill of Rights" to serve as a guide for hospitals and consumers [Appendix A1].
2. **The Resident Bill of Rights.** The federal government legislated a set of resident rights for Nursing home residents as part of the Omnibus Reconciliation Act (OBRA) of 1987. [Appendix A2]
3. **Consumer Bill of Rights for Home-Based Care.** Federal Law also requires that Medicare Home-care consumers be given a set of rights. [Appendix A3]
4. **Rights of Residents in Assisted Living Programs and Residential Care Facilities.** The Maine Department of Human Services identifies rights for people living in assisted living programs and residential care facilities. [Appendix A4]
5. **Rights and Basic Protections for Persons with Mental Retardation and Autism** [Appendix A5].
6. **Rights of Recipients of Mental Health Services**



NOTE: In your role as a health care or human service staff member, it is important to remember that the people who you are supporting have the same rights as any other citizen.

The following sections outline some of the things you should know about the legal rights of the consumers you are working with.

Guardianship and Conservatorship

The purpose of a Guardianship or Conservatorship is to ensure that continuing care is provided for individuals who are unable to take care of themselves or their property because of **incapacity**. A Guardianship or Conservatorship is generally only considered after other alternatives have been explored. The decision of whether a person needs a Guardian or Conservator is made by a Probate Court.

1. **What is Incapacity?**

Maine law says that an incapacitated person is one “who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, intoxication, or other cause . . . to the extent that he (or she) lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his (or her) person” [18 MRSA 5, § 101]. This is more than just being dependent on other people for certain things. The individual must be unable to make or communicate informed decisions about his or her health and safety.

Sometimes an older person, a person with mental retardation, or a person with mental illness isn’t able to make responsible decisions for him or herself. He or she might do things that are dangerous and not understand the consequences. For example, a person might not understand that crossing the street without watching the traffic could cause him to get hit by a car. Another person may not understand about her medication and take the whole bottle. Without meaning to, she could kill herself. Another person might be easily cheated or give away all his money.

2. **What is a Guardian?**

A **Guardian** is an individual, organization, or State agency appointed by the probate court to make decisions on behalf of a person who is incapacitated. The incapacitated person is called a “**Ward**.” A Guardian has the authority to make decisions about the Ward's person, such as . . .

- A. Where the Ward will live.
- B. Whether the Ward will go into a facility such as a nursing or boarding home.
- C. What medical treatment the Ward will receive.

If the guardian is given responsibility for the person’s finances, this is limited to administration of a person’s affairs when value of all assets is under \$5,000. When assets exceed this amount, the court appoints a **Conservator** with responsibility for managing larger financial assets.

If the Ward receives a check from Social Security, the Veterans Administration, or another federal agency, the Guardian will need to apply to become Representative Payee, as described later in this module.

3. What is a Conservator?

A Conservator is a person appointed by the Probate Court to protect and manage the money and property of any person who is unable to manage his or her own property because of a mental or physical illness or disability. The person under Conservatorship is called a "Protected Person." The Conservator can do such things as:

- A. pay the Protected Person's bills
- B. sell, mortgage, rent out or manage the person's real estate
- C. invest the person's money.

The Conservator is not allowed to make decisions about the Protected Person's personal life unless he or she is also appointed as the Guardian. The conservator also is not allowed to write a Will for the Protected Person.

4. What Is the Relationship Between a Conservator and Guardian?

A guardian makes decisions about the ward's life and well being. If there is no Conservator appointed, a guardian also may have *limited* authority over the ward's money and property. If the ward owns real estate or has a substantial amount of money or property, the Probate Judge will generally appoint a Conservator to make decisions about the ward's money and property. The same person can be both guardian and conservator or there may be a different person for each responsibility.

5. Who May Serve as Guardian or Conservator?

In appointing a Guardian or Conservator, the Judge will look for a person who knows the individual well, who will make good decisions for him or her, and who will spend the time needed to do a good job. The Court prefers to appoint close relatives or someone chosen by the individual while he or she was still competent. The law does not allow an owner, administrator, or employee of the nursing home or other facility in which the person might be living to serve as Guardian or Conservator unless he or she is a relative.

In some cases, there are incapacitated people who have no relatives or friends available to serve as Guardian or Conservator. In these cases, the Court may appoint a State agency (either the Department of Human Services or the Department of Mental Health, Mental Retardation and Substance Abuse Services) as the person's Guardian or Conservator. If this happens, a caseworker from one of these agencies assumes the same responsibilities as a friend or relative appointed Guardian or Conservator.

6. How is a Guardian Appointed?

If parents, relatives, the state, or others believe that a person has become incapacitated, they can ask (petition) the Probate Court to appoint a guardian to make decisions for the person. The probate judge will read

reports and hear testimony from the individual and others who know the individual before deciding whether the person needs a guardian. The court uses the opinion of a licensed physician or psychologist in making this decision. The judge will also decide what kind of guardianship is needed and who will be the guardian.

The guardian can be a person, an organization, or even an agency of state government. The guardian is given the legal authority by the judge to make decisions on behalf of an incapacitated person. The individual surrenders (sometimes involuntarily) most decision-making in his or her life.

7. **Managing Money and Property as a Fiduciary**

In handling a person's money or property as a guardian or conservator, the guardian or conservator is acting as a **fiduciary**. This means that the guardian or conservator is required to use the money or property for the benefit of the ward or protected person. A guardian or conservator may not treat the money or property of the ward or the protected person as if it were the guardian's or conservator's own funds and use them for his or her own benefit or for the benefit of family or friends. If a guardian or conservator does so, then he or she could be prosecuted for a crime or required by a court to pay back the value of what was taken from the ward or protected person.

A person's guardian *can* be changed or removed under certain circumstances. If a guardian is neglecting their duties, or is not making decisions in the ward's best interest, the court may appoint a different guardian. If a person under guardianship becomes better able to make their own decisions, they can ask the court to change or end their guardianship.

8. **Types of Guardianship**

There are several types of guardianship that you should be aware of.

Under **full guardianship**, the guardian may decide where the person will live. The guardian also can give consent for medical treatment or any other professional care or service. The guardian may approve the person's placement into a hospital or institution. However, the hospital or institution may deny any request for admission. A person under guardianship may not enter into any contract, make legally binding agreements, or marry without their guardian's permission.

The court also may appoint a **limited guardian**. A limited guardian has the authority to make only specific kinds of decisions, such as giving consent for medical treatment or making financial decisions. Under limited

guardianship, a person has the right to make any decisions that have not been specifically granted to the guardian.

Since the law requires that the Probate Court help the incapacitated person stay as independent and self-reliant as possible, a limited guardianship or conservatorship is always preferable to full guardianship or conservatorship.

Guardianship is generally a life-long arrangement, but in some emergency situations the court may appoint a temporary guardian, usually for a period of six months or less, to handle a person's affairs until they are no longer incapacitated or until a permanent guardian can be found.

9. Rights and Responsibilities of the Guardian

The guardian generally has the same rights and responsibilities as the parent of a minor child, *except*:

- A. the guardian does not have to pay the expenses of the ward using his/her own money
- B. the guardian is not legally or financially responsible for acts of the ward.

The guardian is expected to ensure the care, comfort, and protection of the ward's person and property. The guardian is to respect the wishes of the ward and to act in the ward's best interest. These rights and duties may be specifically limited under a limited guardianship.

The authority of the guardian may be limited by other state laws. For instance, a guardian does not have the authority to have the ward sterilized or admitted to a state institution. Also, the guardian has the authority to give consent but may not be able to force the ward to act according to the guardian's decision. A guardian may decide that the ward should live in a certain home but may not force the ward to stay there.

10. Working with Guardians

Most guardians take an active interest in their wards. It is important to keep the guardian up-to-date about what's happening in the ward's life. This will help the guardian make informed decisions. It is especially important that the guardian know the ward's likes, dislikes, and the extent to which the ward is able to make his/her own decisions. Some guardians have complained that they never hear from staff unless there is a problem. Talk with your supervisor to find out how you are expected to communicate with guardians.



NOTE: There may be times when a guardian expects you to do something that you disagree with. Explain to the guardian that you need to talk to your supervisor. Also talk with your supervisor if you feel that a guardian is making decisions that are not in the ward's best interest.

Representative Payee

What Is a Representative Payee?

Most people that are retired or disabled receive a check of some kind from a federal agency, such as Social Security or the Veterans' Administration. If the recipient is unable to manage the money appropriately because of a disability, family members or friends may want to help by taking control of the money to spend it on that older person's needs. To do so, they must apply to the agency paying the benefits to be appointed Representative Payee.

The Representative Payee is responsible for receiving the older person's check and spending it on his or her care and support. The older person (called the Beneficiary) may request that a Representative Payee be appointed if he or she realizes that failing health may soon make it difficult to manage money. However, usually it is a concerned relative or friend, or perhaps a nursing or boarding home concerned about getting paid, who seeks to have a Representative Payee appointed.

Health Care Advance Directives

When you need medical care, you have the right to make choices about that care. But there may come a time when you are too ill to make those choices known. You can protect your right to choose by making decisions ahead of time about the medical care you may want in the future. This is called giving an **advance directive**.

Adults should be encouraged to make an advance directive, especially upon entry to a facility or home care situations. This simplifies matters and protects the person's wishes should such authorization be needed at a later time. An advance directive not only protects a person's right to make medical decisions that affect his/her life but also helps the family and physician by providing guidelines for the person's care.

There are three common types of advance directives:

- A. Durable Power of Attorney for Health Care
- B. Living Will
- C. Do Not Resuscitate (DNR) order.

1. **Durable Power of Attorney for Health Care**

A person may, if he or she chooses, legally transfer authority over some areas of his/her life to a friend or relative who will thereby have Power of Attorney.

A **Power of Attorney** is a legal document that authorizes someone to act on behalf of another person. Power-of-Attorney may be limited and apply to only certain areas, such as management of the person's finances or property. It may also be total, in which case the person with such authority may administer all areas of the person's affairs. A Power of Attorney may be withdrawn or revoked by the individual if he or she no longer desires such an arrangement and is still competent to make that decision. A power of attorney is said to be durable if it remains in effect when the person can no longer make decisions for him or herself.

A **Durable Power of Attorney for Health Care** lets you choose another person to make health care decisions for you when you are too ill to make decisions about your own care.

The person who is chosen to make health care decisions is called the Agent. A consumer may also name a Successor Agent in case the first person chosen is unavailable. Neither the consumer nor the Agent needs to be a lawyer.

The Agent must make decisions according to any instructions the consumer has given and wishes she had made known while competent and must consider her personal values. For example, a consumer can state that she is opposed on religious or personal grounds to a particular form of medical care. The Agent must abide by these wishes.

A consumer also may limit the kinds of decisions the Agent can make. If the individual does not place any limits on the Agent's authority, the Agent will have authority to make any and all health care decisions - including the authority to consent or withhold consent to any care and treatment, choose the physician, place the person in an institution such as a nursing home, and decide whether the person should be kept alive by artificial means if he is terminally ill.

As long as the person is still competent to tell the doctors and nurses what she wants, they will (and should) listen to the consumer and follow her instructions about what care she wants to be given. The doctors and nurses will seek out her Agent under the advance directive *only* when the consumer is no longer competent or able to express herself unless she has indicated otherwise.

2. Living Wills

A **Living Will** allows a person to express his/her wishes about end-of-life decisions in the event the individual has a terminal condition and can no longer communicate with his doctor. It is called a Living Will because it takes effect while the consumer is still alive.

A person may write his/her own Living Will or he/she may create one by filling out Part 2 of the Maine Health Care Advance Directive Form. While some people may want to prolong their life, others may want to refuse medical measures that would prolong life if the chances of recovery are not good. Examples of life prolonging measures include the following: cardiopulmonary resuscitation (CPR), the use of electric shock to restart the heart, tube feeding, respirators, and kidney dialysis. A Living Will allows consumers to decide whether they would like to receive or refuse life-prolonging measures. Among other things, the consumer may indicate whether he would like to receive or refuse artificial nutrition and hydration and whether he would like to receive treatment for the relief of pain and discomfort.

3. Do Not Resuscitate (DNR) Orders

A **Do Not Resuscitate (DNR)** order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if a consumer stops breathing or his heart stops beating. A consumer can use an advance directive form or tell the doctor and nursing staff that he does not want to be resuscitated. In this case, a DNR order (written by the doctor) is put in the consumer's medical record.



NOTE: Do not resuscitate orders **MUST** be re-signed every six months.



For More Information: For more information about the legal options available, see Aging: Taking Care of Business on the BEAS website: <http://www.state.me.us/dhs/beas/welcome.htm>

Abuse, Neglect, and Exploitation

Abuse, neglect, and exploitation happen to thousands of adults in Maine every year. Many people are uncomfortable talking about these problems, especially if the abuser is a family member or friend. However, help is available if people are aware of the problem and take steps to report it.

1. Abuse

Definition of Abuse

"Abuse" means the infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish; sexual abuse or exploitation; or the willful deprivation of essential needs.

A. Physical Abuse

Physical Abuse includes actions that result in bodily harm, pain, or mental distress. Some examples of abuse are:

- i. Pushing, hitting, shaking, pulling hair
- ii. Tying to a bed or chair or locking in a room
- iii. Forcing into sexual activity
- iv. Giving the wrong medicine or too much medicine on purpose
- v. Denying visits with friends or family
- vi. Harassment or verbal threats.

There may be times when you observe signs of abuse, but you were not actually a witness to what happened. The tangible signs or indicators of abuse, neglect, or exploitation described on the following pages tend to be ones that can be detected by trained observers. More difficult to detect or to determine are intimidation and mental anguish. Consumers who are ridiculed, maliciously teased, cursed at, or threatened may fear retaliation if they speak up or complain about a family member, another consumer, or a member of their staff. It takes skill and sensitivity beyond that required for routine observation to find out if verbal abuse has occurred.

Indicators of Abuse

Physical assaults, cruel discipline, excessive use of physical or chemical restraints, and unnecessary or incorrect medication may cause any one of the following:

- i. **Broken Bones:** Pain and inability to move a limb may be a sign of a broken bone. This may occur when a consumer with osteoporosis is handled roughly by visitors or staff members. Broken bones in various stages of healing and spiral fractures may indicate abuse as well as fractures of the skull, nose, or facial structure.
- ii. **Burns:** Burns and blistering skin over a wide area may show up because a consumer was placed in a scalding hot tub of water. A more confined spot of burned skin may indicate purposeful

burning with a cigarette. Rope burns on the arms, legs, neck, or torso may also indicate abuse.

- iii. **Cuts:** Cuts or scratches may result when a consumer was jabbed with a sharp object such as a pencil or scratched with fingernails.
- iv. **Internal Injuries:** Watch for such signs as vomiting, pain, stuporous states, bleeding, swelling or bloody stools. You may observe any one or a combination of these if someone gave a consumer alcohol or drugs that can cause sickness; or if someone overdoses a consumer with anti-diarrhea medicine causing severe constipation; or if a blow to the stomach or head has caused internal injuries.
- v. **Marks/Bruises:** A consumer may have a handprint shaped bruise where a person slapped them across the face or buttocks. Multiple bruises in various stages of healing may indicate abuse. Look for injuries to the face, neck, inner arms, inner thighs, and especially bilateral injuries on upper arms.
- vi. **Scars:** Scars could indicate that the consumer has been a victim of repeated or past abuses.

B. Sexual Abuse

Definition of Sexual Abuse

"Sexual abuse or exploitation" means contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult's consent (22 MRSA §3472).

Indicators of Sexual Abuse

- i. A family member offers affectionate gestures to a consumer that are too lingering and seductive or become centered on the sex organs, anus, or breasts.
- ii. Injury to a consumer's genitals, anus, breast, or mouth.
- iii. A consumer attempts to talk an incapacitated consumer into sexual intercourse, fellatio, or cunnilingus.
- iv. A young consumer tells you that her father manipulates her genitals, buttocks, and breasts during his visits.

- v. A staff member exposes his/her genitals to a consumer.
- vi. Venereal disease, torn, stained or bloody underwear, difficulty walking or sitting, and pain or itching in genital area are all potential indicators of sexual abuse.

C. Neglect

Definition of Neglect

"Neglect" means a threat to a person's health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these (22 MRSA §3472).

Consumers suffer from neglect when they are left alone, ignored by family members of staff, or left with other people who fail to care for them appropriately.

Indicators of Neglect:

- i. A group of assaultive consumers have been left alone and unsupervised.
- ii. An aide has fallen asleep or is intoxicated while on duty.
- iii. A consumer has bleeding gums and some loose teeth, indicating that a visit to the dentist is long overdue.
- iv. A consumer is continually fearful about leaving her room or home and seems almost panicky when it's time to leave for an outing.
- v. Staff "leave her be" rather than attempting to determine the cause of her fear.
- vi. A consumer fell several days ago. Her ankle is swollen and bruised, and she complains of pain when walking. The consumer's doctor or family was not notified of the fall immediately. X-rays taken several days after the fact reveal a fracture.

D. Exploitation

Definition of Exploitation

"Exploitation" means the illegal or improper use of an incapacitated adult or his resources for another's profit or advantage. (22 MRSA §3472)

Indicators of Exploitation

- i. A consumer's relative, who is the representative payee, fails to pay nursing, boarding, or foster home bills and provide personal needs money.

- ii. The facility administrator, who is a consumer's representative payee, purchases furniture or clothing not intended for the consumer.
- iii. A consumer is manipulated into giving away money or personal property such as a TV, jewelry, or furniture.
- iv. Disappearance of personal property; transfer of property, savings, insurance; unexplained change in cash flow; change in will, representative payee, or power of attorney; or depleted bank accounts.

E. Types of Abuse, Neglect, and Exploitation

Abuse may occur in a variety of ways. Consumers may abuse one another, staff may abuse consumers, or consumers may be abusive toward staff. Abuse may be an act of violence such as physical or sexual assault, or it may be verbal abuse, medication errors, or failure to provide proper assistance resulting in injuries. Consumers may be neglected by staff or family members. Consumers may be exploited by staff, family members, or other consumers.

F. Consumer Risk Factors

A consumer is more at risk for abuse, neglect, and exploitation if he/she is:

- Argumentative
- Assaultive
- Demanding
- Hostile
- Incompetent, organic brain syndrome (OBS), demented
- Incontinent
- Intrusive
- Manipulative
- Mute
- Passive/passive aggressive
- Verbally abusive

OR, if he/she has a history of:

- Multiple incidents
- Substance abuse
- Sexual acting out behavior

G. Mandatory Reporting

Maine law (22 MRSA §3477-3479-A) requires that if the following people, while acting in a professional capacity, suspect that an adult has been abused, neglected or exploited, and there is reasonable cause to suspect that the adult is incapacitated, then those

professionals shall immediately report or cause a report to be made to the Department of Human Services.

Individuals who are mandated to report while acting in a professional capacity include:

- i. ambulance attendants
- ii. Certified Nursing Assistants
- iii. chiropractors
- iv. coroners
- v. dentists
- vi. Emergency Medical Technicians (EMTs)
- vii. emergency room personnel
- viii. law enforcement officials
- ix. Licensed Practical Nurses (LPNs)
- x. medical examiners
- xi. medical interns
- xii. mental health professionals
- xiii. Occupational Therapist
- xiv. Pharmacist
- xv. Physical Therapist
- xvi. Physician (MD and DO)
- xvii. Physician's Assistant
- xviii. Podiatrist
- xix. Psychologist
- xx. Registered Nurse
- xxi. Social Worker
- xxii. Speech Therapist
- xxiii. Unlicensed Assistive Personnel

Other Individuals who are mandated to report

Any other individual who has assumed full, intermittent, or occasional responsibility for the care or custody of an adult, whether or not the individual receives compensation.

Facility Reporting

Maine law further states that whenever a person is required to report in his or her capacity as a member of the staff of a medical, public or private institution, facility or agency, that person shall immediately make a report directly to the Department of Human Services.

Optional reporting

Any person may make a report if that person knows or has reasonable cause to suspect abuse, neglect, or exploitation of a dependent or incapacitated adult, or has reasonable cause to suspect that an adult is incapacitated.

Where to Report

Mandatory and optional reports are made to Adult Protective Services in the Bureau of Elder and Adult Services at DHS. When the alleged victim has mental retardation, the report must be made to Behavioral and Developmental Services.

A report made by telephone is usually sufficient, although the Department of Human Services may request a mandated reporter to file a written report within twenty-four hours. Any report by a mandated reporter must include the name and address of the involved adult; information regarding the nature and extent of the abuse, neglect, and exploitation; the source of the report; the person making the report; his or her occupation; and where he or she can be contacted. The report may contain any other information that the reporter believes may be helpful.

Immunity

When reports are made in good faith, reporters are immune from any civil liability. Facility staff members who comply with the mandatory reporting law also are protected from discharge, threats, or discrimination regarding their conditions of employment by their employers under Maine's "whistleblowers protection act" (26 MRSA §831-840).

Confidentiality

The Department will respect a request for confidentiality. All department records and activities are confidential. Disclosure may be required in very limited circumstances.

Report abuse neglect or exploitation in **licensed nursing facilities** to the Department of Human Services, Division of Licensing, and Certification.

Statewide toll-free: 1-800-383-2441
TTY: 624-5512

Report **all other** adult abuse, neglect, or exploitation to Bureau of Elder and Adult Services, Adult Protective Services at:

Statewide 24-hour Toll Free: 1-800-624-8404
TTY during business hours: 1-800-624-8404
TTY after hours: 1-800-963-9490

To make a report of abuse, neglect or exploitation of a person **with mental retardation**, call Behavioral and Developmental Services (BDS), formerly, the

Department of Mental Health, Mental Retardation and Substance Abuse Services.

Portland Office, Region 1 (York & Cumberland):

207-822-0270 (TTY 207-828-0272)

Augusta Office, Region 2 (Central & Mid Coast):

207-287-2205 (TTY 207-287-1798)

Lewiston Office (Androscoggin, Franklin, & Oxford):

207-941-4360 (TTY 207-941-4392)

Thomaston Office (Knox, Lincoln, Sagadahoc, & Waldo):

207-596-2300 (TTY 207-941-4392)

Bangor Office, Region 3 (Hancock, Piscataquis, Penobscot, & Washington):

207-941-4360 (TTY 207-941-4392)

Presque Isle Office (Aroostook):

207-554-2100 (TTY 207-764-2000)

If not successful, and for after business hours reports, call the CRISIS NUMBER at 1-888-568-1112



NOTE: As a staff member, you should become familiar with these agencies and contact them when abuse, neglect, or exploitation is suspected. Such reporting is confidential and state law protects those who report from legal reprisal ***if they report in good faith.***

H. Other Resources and Interventions

Several other state agencies are involved in protecting the rights of consumers.

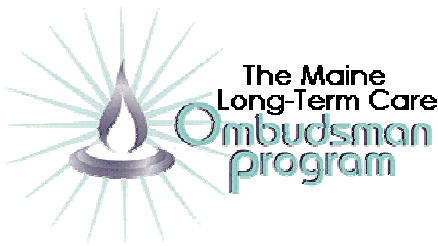
- i. **Adult Protective Services (APS)**, in the Bureau of Elder and Adult Services, provides a number of services designed to protect all adults from abuse, neglect, and exploitation. The APS staff also petition for Public Guardianship and/or Conservatorship of incapacitated adults when all less restrictive alternatives have failed.

Adult Protective Services works with people who are victims of physical abuse, unreasonable confinement, neglect, financial exploitation, and sexual abuse. Verbal abuse, intimidation, and deprivation of food, water, or medical care are other forms of danger to which people are subjected. Danger may also include self-abuse or self-neglect. APS represents people who are frail and elderly, people with mental illness, people with substance

abuse problems, people with medical problems, and people with disabilities.

Contact Adult Protective Services by calling 1-800-624-8404

- ii. **The Long-term Care Ombudsman Program** investigates and resolves complaints made on behalf of consumers of Maine's nursing facilities, assisted living facilities and recipients of home care and adult day services. Any person may ask for assistance from the Ombudsman Program on behalf of these individuals. The Ombudsman receives complaints directly from consumers, from friends and relatives, employees and administrators, and public agencies and community groups. They include complaints about the quality of care that a consumer receives in a long-term care facility or at home, and about problems that consumers have regarding eligibility for state programs, financial status, legal problems, and transfer assistance. The Ombudsman Program also provides training on consumer rights and on federal and state regulations and identifies issues that may require legislative or regulatory changes.



Contact the Maine Long Term Care Ombudsman Program at:

One Weston Court, P.O. Box 128

Augusta, ME 04332-0128

207-621-1079 (Voice/TTY)

Toll Free Statewide: 1-800-499-0229 (Voice/TTY)

Email: MLTCOP@MaineOmbudsman.org

Website: www.maineombudsman.org

Ethics

Ethics are concerned with what is right and what is wrong. They are guides to behavior. Ethics are principles that influence how we work and our behavior at work.



NOTE: There may be times when your personal ethics (what you think is right and wrong) conflict with a Federal or State regulation. In these circumstances it is best to consult with your supervisor for guidance about how you should handle the situation.

There are general human service and nursing ethical guidelines that can help to guide your work (see Appendix B).

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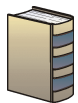
Module 4: Communication



OBJECTIVES

After completing this module, you will be able to do the following:

- Identify the parts (e.g., sender, receiver, message) and the potential barriers to communication;
- Identify the methods of communication (e.g., verbal, body language, listening);
- Explain the Active Listening strategy for improving communication
- Explain appropriate communication between health care and human service workers and consumers;
- Explain appropriate communication between an employee and others, including, staff members, supervisors, family, and friends; and
- Describe strategies for communicating with people that have physical, emotional, cultural, and social impairments.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Sender
- Receiver
- Message
- Feedback
- Clarify
- Barrier
- Verbal or Oral Communication
- Body Language
- Non-verbal Communication
- Personal Space
- Active Listening
- Need-to-Know
- Aphasia
- Alzheimer's Disease
- Stereotypes
- Ethnocentrism
- Prejudice

Communication

Most of the information in this module was adapted from the Georgia Long Term Care Ombudsman volunteer Trainer's Manual. Used with permission by the National Long Term Care Ombudsman Resource Center, Washington, D.C.

Communication is the single most important tool staff members use to deliver service. Consumer and consumer support, problem solving, team intervention, crisis management, skills teaching, and service planning, and many other functions all rely on effective communication. Many of the problems that arise in health care and human service settings are a direct result of misunderstanding or poor communication.



Therefore, understanding the process of communication and improving your skills in this area are very important steps in doing a good job.

Some communication problems are due to the structure of the organization and lack of direction from supervisors. However, many difficulties are due to staff attitudes and assumptions about communication that are inaccurate or untrue:

- One assumption people make is that their communication skills are great simply because they are caring and want to "help" or "take care of" people. Roughly, the thinking is: "Because I am committed to being helpful, what I have to say is clear, appropriate, and gladly received by consumers, fellow staff members, and other people." This type of thinking is not only untrue, but it also leads us to be defensive when our communication skills are questioned.
- Another assumption is that all our messages are understood clearly because we are speaking the same language. Using one language (e.g., English) does not mean that we will understand one another. Regional and generational uses of words may vary. The word "molested" today has a sexual meaning or connotation. About 50 years ago, however, the word "molested" meant to "handle roughly," and it had no association with sexual acts.

The word "bit" is also used very differently today than in 1955. How was it used then? How is it used now? Working with persons of different generations can produce misunderstanding in spite of the fact we are all speaking English. Individuals for whom English is a second language may not understand all the phrases we use such as the one in this sentence: "Can you 'stick it out' for the whole shift?" What does that mean literally?

What else can it mean?

- A third assumption made by service workers is this: if I raise my voice, the message will become clearer to the listener. This is not even always true for persons with hearing disabilities. For many people, a loud voice will actually *decrease* the amount they hear. Many of us have seen situations in movies or on TV when someone has instinctively yelled their message to a deaf person, an older person, or someone from another country in an attempt to get their message across.
- Lastly, we assume that the communication skills we developed for use in our social lives are appropriate and good enough to use at work.

There are two types of communication. The first is our normal, social communication consisting of a give and take between peers. The second is therapeutic communication. The type of communication you should use at work is therapeutic. Here, the focus of the communication is on the person needing support. It is not an equal sharing.

Can you think of other assumptions you have about your communication skills? Research suggests that human service workers make the *same* communication errors as people in other fields. We are just like everyone else when it comes to our proficiency with these skills. The issue for health care workers is that communication takes on an added importance as we seek to teach, plan, support, and advocate. The communication we have with others at work will directly affect their lives and well being in significant ways. Therefore, it is important for us to develop our skills in this area.

Understanding the Communication Process

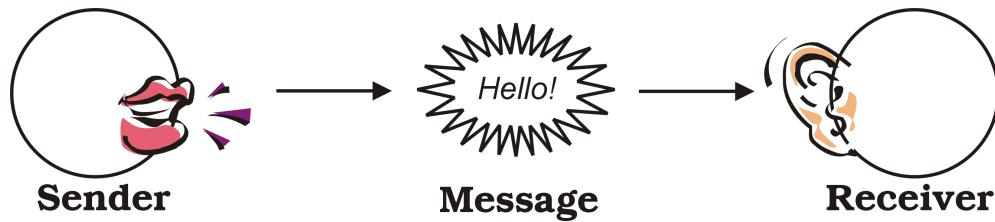
Communication is something everyone engages in, some with more skill than others. In much of our communication, the focus is on the content of conversations. We listen to what people are saying to us and attempt to respond. More often we listen only slightly to what the other person is saying while we are thinking of a response. Conversations may become a series of one-way speeches.

Communication is usually more rich, varied, and subtle than we realize. It is the art of sharing information with others.

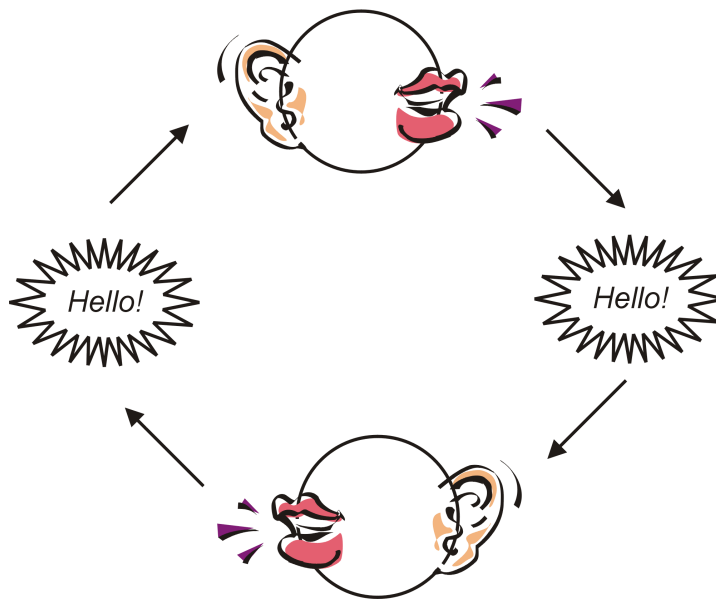
The communication process has three main components:

1. **A Sender:** the person who gives out the information
2. **A Receiver:** the person who gets the information
3. **A Message:** the information itself

The information flows from the sender to the receiver in the form of a message.



During a normal conversation, you will switch between the two roles. Sometimes, you will be the sender. Sometimes, you will be the receiver.



Note that this is a circular process that involves feedback, clarification, discussion, conflict resolution, and problem solving.

Feedback is the receiver's response to the sender's message. The receiver's feedback lets the sender know if the message was understood.

If it appears as though the message has been misunderstood, the receiver may ask the sender to **clarify** what he/she has said (e.g., repeat the message or restate it in a different way).

It is important to remember that good communication is never one-sided.

Barriers to Communication

Unfortunately, the above diagram also demonstrates an inherent problem in communication. You may call them obstacles or **barriers** to clear and meaningful communication. They are things that get in the way of a clear communication process. Barriers may occur at the sender level, the receiver level, or in the message transmission itself.

There are several kinds of communication barriers that you will encounter during the course of your work:

- The language is not common to both sender and receiver
- The sender has speech difficulties such as stuttering or aphasia
- The receiver has a hearing impairment
- The sender's body language and message do not agree
- There is background noise and lights getting in the way of the message
- There are other people in area
- The receiver has difficulties processing the message
- The sender is demonstrating emotions like boredom or being rushed.

Recognizing and eliminating barriers will improve your communication.

Try to identify the communication barriers in the following example:

John, a staff member, enters the day room in the nursing facility. There are several people in the room. Some are watching television and one is playing the piano. Sam is sitting in a chair reading and looking rather sad. John approaches Sam and says, "Wie geht's?" Sam looks at John startled by the question and turns up his hearing aid. He says "What?" John repeats "Wie geht's?" but with a louder voice. Sam gets up and turns down the television. He repeats "What?" John just looks at Sam and walks off. Sam begins to cry. There are several barriers in this scenario. Can you name them?

- John is practicing his German on Sam since Sam grew up in Germany and John assumes he can speak the language. He is asking Sam "How is it going" but Sam speaks English. Obviously, this hampers the communication. (Sender)
- Sam is hard of hearing. He wears a hearing aid and it was not on. (Receiver)
- The noise from the television was too loud. (Message)

Did John practice effective communication skills? Did he do the right thing? The answer is no. John's job as the staff member is to recognize and reduce the effect of barriers in the communication process. Notice also the effect on the sad consumer. This communication actually made his situation worse.

Now, let's review what should have happened in this situation.

John, the staff member, enters the dayroom where some people are watching TV. Sam is sitting in a chair reading and looking rather sad. John goes to Sam, stands in front of him tapping him lightly on the arm. Sam looks up and turns up his hearing aid. Once Sam does, he realizes the TV is too loud and goes to turn it down. John says, "Wie geht's?" Sam shakes his head and shrugs looking at John in a puzzled way and says, "What?" John realizes that Sam can hear him but doesn't understand the message. John says, "Sam, I thought you may be homesick so I was trying my hand at German. Guess I didn't do too well. You look upset. Do you want to talk about it?" Sam replies, "Your German is lousy. I feel lousy and this is why..."

You can see here how John recognized and sought to reduce barriers so that the communication process was clearer. This sensitivity and intervention requires practice.

1. Work Behavior can also create Barriers to Communication

No one likes to hear bad or sad news. Sometimes a remark or information about a situation is personally threatening to a staff member because of the memories or fears they bring up. Nevertheless, within your role as a staff member, you will sometimes hear consumers discuss all of the above. Your response can erect a barrier to communication or it can open the door to understanding and trust. It can mean the difference in being effective as a staff member or being ineffective. In fact, the way you respond will make the difference in whether or not consumers confide in you. Some barriers to communication and examples follow.

A. Changing the subject when the topic is uncomfortable for you

- i. If a person wants to talk about death and dying or about how much he misses his wife, don't change the subject because you find the topic morbid or depressing.
- ii. Maybe the person wants to express her anger towards her daughter. Hearing this makes you uncomfortable because you know the daughter. Your role as a staff member is to listen and hear the consumer's position. You ARE NOT in a position to defend the daughter. If ever there is a case where you cannot maintain an objective perspective, discuss your concerns with your supervisor.

B. Offering false hope and reassurances

- i. When a person says she hopes her doctor (son, daughter, etc.) comes soon, refrain from saying, "I'm sure he will." Be positive about the statement you make before you speak.
- ii. A person tells you, "I hope I get over this problem soon; I don't know what I will do!" Don't say, "I'm sure everything will work out fine." Also avoid statements like, "Don't think about things like that."

C. Glossing over information the person shares with you about the facility or about her treatment. Tuning out or selectively hearing problem statements.

- i. If a person says, "the other staff don't treat me very well, but I'm managing to take it one day at a time." Don't respond, "Well, you know they have a big job to do and can't please everyone."
- ii. A person might say, "I never get bathed and dressed in time for the morning craft class." In reply, a statement like, "I'm sure the other staff members work as fast as they can. This is a big facility and someone has to be at the end of the schedule," might suggest that you do not care about his well being.

D. Assuming the role of "neighborhood friend" when someone is revealing personal information.

- i. A person describes her physical problems. Do not say, "My grandmother had that and. . . ." (Discuss your grandmother's condition).
- ii. A person confides in you. Your response is, "I know what you're talking about," and proceed to tell the person all about your situation. That kind of response does not pick up on what is important to the person. It shifts the focus of the conversation to you.

E. Allowing the other staff to monopolize your time.

- i. Although cultivating a good working relationship with the other staff members is very important, your job is to work with the consumers. Your coworkers can, either consciously or unconsciously, take up much of your time. Be sure your conversations with your coworkers are purposeful, not just friendly chat sessions. This can erect a barrier to communication by severely limiting the amount of time you have with the consumers.

One or more of these five barriers may be very natural and easy to slip into without being aware of what you are doing. Some of these barriers represent ways we have of protecting ourselves or of controlling

conversations. They are not appropriate in your role as a health care or human services worker.

Setting the Stage for Communication

There are some factors that can prepare the way for your interaction with another person. These can increase the chances that your communication will go the way you would like.

- Always introduce yourself, using your name and role unless the person knows you already. Do not ask the person, "You remember my name, don't you?" or a similar question.
- Greet the person by Mr., Mrs., Miss, or Dr., and last name unless the person asks you to use another name.
- Always knock on the door to a person's room or house before entering, even if the person can't verbally respond or if the person is watching you approach. Knocking acknowledges that the room is their space and home. It also conveys a sense of respect for their privacy and dignity.
- Choose an appropriate place for the type of conversation or visit you plan to have with the person. If you are just greeting people, a day room or porch setting is appropriate if that is where the people are sitting. If you need to discuss personal information, find a setting with privacy and few distractions. The setting in which communication occurs directly impacts the nature of the interaction.
- Cultivating friendly and trusting relationships takes time. Be consumer in visiting. Allow people to get to know you while you are learning about them. Rarely does a person divulge their innermost thoughts or problems until a trusting relationship has been established.
- Be dependable. Visit or check back when you said you would. *Promise only what you can deliver/control.*
- Be honest. Avoid giving false hope or stating platitudes. It is OK to admit, "I don't know."

Verbal Communication

The use of spoken words to send a message is **called verbal or oral communication**. There are two key components of this type of communication:

1. Voice tone and language usage

2. The content of the message.

Voice tone can add meaning to the words that are spoken. The tone of your voice often holds significant clues as to the underlying meaning of a statement. Voice tones certainly place emphasis where the speaker intends. Consider, for example, how the word "Yes" can assume different meanings by varying the tone of expression.

If it is said. . .	softly	It can mean . . .	friendliness
	loudly		anger
	sharply		annoyance
	rising		a question

Words are unique to humans. Depending on how it is used, conversation can create understanding or complete misunderstanding. Carefully chosen words bridge gaps and can also be used to mend fences. Be sure that the words you use have the same meaning for the person with whom you are speaking as they do for you.

For example: If you told an administrator that Mrs. Jones lost her purse, would the administrator think that the consumer forgot where she placed her purse? Would he think that Mrs. Jones's purse was stolen?

For example: If you asked Mr. Green how he spends his time, would he laugh at you and say, "I can't spend time! I can only spend money and I don't have any of that!"

Nonverbal Communication

Another part of the communication process is **body language**. Body language is the unspoken communication that goes on in every face-to-face encounter with another person. Research has shown that the message as understood by the receiver is composed 30% of the words spoken and 70% of the nonverbal communication or body language which accompanies it. In other words, what you say is not often as important as how you say it. Consumers are sensitive to body language. For some people, it is easier for them to understand the nonverbal message.

If you want to be clear, you must be sure that your words and nonverbal body language both convey the same message.

Let's take a look at the following example:

Jackie is a new staff member. She is anxious to help but unsure of herself. She approaches Mary who seems upset. Jackie says, "Mary,

you seem upset. Tell me about it.” However, she says this to Mary while she is standing in front of her frowning (due to a headache) with her arms crossed. The verbal message is” I hear, understand, and will help”. The nonverbal message is” I am staff and do not have time so hurry up and tell me what is going on.” Mary now does not know how to respond. This message is mixed. It will confuse her. If Jackie went in, sat down next to Mary, took her hand, and said the same words, the message would be different. Her body language would say” I am here for you with time to listen. Let me help.” That is the message that Jackie wanted to convey.

- What were the barriers to communication? Were proper accommodations made by staff member?
- Did the verbal and nonverbal parts of the message say the same thing? Why or why not?

As a staff member you can promote the easy and clear flow of communication by being aware of you facial expressions, nonverbal gestures, and body position.

1. Facial Expressions

Seldom are we expressionless. Our faces portray a wide range of emotions and reactions, such as caring, disgust, inattention, or doubt. Facial expressions can be used to show that we understand or are in agreement (smiling or nodding) or can show we do not understand and need clarification (a questioning look or eyebrow tightened).

2. Eye Contact

The eyes themselves can send several kinds of messages. Meeting someone's glance indicates a sign of involvement or of confidence in our culture. Looking away signals a desire to avoid contact. Establishing eye contact indicates an interest in what someone is communicating. Eye contact should be spontaneous, where the listener looks at the speaker but also lets the eye drift occasionally. A person's comfort level with direct or sustained eye contact is influenced by that individual's culture and background.

3. Touching

Touching is an important type of nonverbal communication. Touch is particularly significant to the older person. As people age and become detached from the mainstream of society, and as they experience both personal and social losses, chances for personal contact decrease. Thus, touching becomes a meaningful contact.

Touching is especially effective with individuals who have sensory impairments or who are having difficulty concentrating. Sometimes a touch of the hand can help a person focus on your conversation. At other times, that kind of touch serves to establish a bond.

Touching can convey warmth, caring, understanding, sympathy, and compassion.

Touch expresses to the other person an acknowledgement of his/her existence. It says, "You are still a person with life and dignity."

As important as touch is, remember that touching and one's comfort with being touched is a very individualized characteristic. Some people like to be touched; others do not. Some people may even be tactilely defensive or sensitive, which means that they are highly sensitive to touch. Be aware of each person's response to touching. Get to know the consumer and let her know you before you use this communication technique.

4. Distance/Personal Space

The way people use space is also part of nonverbal communication.

Personal space refers to the distance that we put between others and ourselves. There are four distances that we use, depending on how we feel toward the person with whom we are communicating.

Intimate distance is usually reserved for people with whom we feel emotionally close. The zone begins with skin contact and moves out to about 18 inches.



Personal distance can range from 18 inches to about 4 feet. Here again, the contact is rather close but less personal than the intimate distance.



Social distance, the third zone, ranges from 4 feet to 12 feet. This is the distance at which most professional situations occur.



Public distance runs outward from twelve feet. The closer range of public distance is the one most teachers use in the classroom.



As you seek to communicate effectively with others, you must be aware of their personal space. If you are trying to establish rapport, you should respect their comfort with various degrees of physical closeness. There may be other times when you will purposefully "invade" someone's personal space.

5. **Gestures and Movements**

Two other methods of conveying feeling and attitudes are gestures and movements. Gestures can be used to punctuate a statement; for example, pointing to emphasize or signaling to get attention. Movements all too often indicate tension or boredom.

Shifting in one's seat, foot tapping, or finger drumming, all suggest that you are being inattentive and should be avoided. By paying attention to these, you can tell when a person is nervous, exhausted, ready to end your visit, or any one of a number of other messages. Gestures and movements do have meanings. To be skilled as a communicator, you need to be able to read their meanings and to effectively use gestures and movements to convey your messages.

6. **Silence**

Sometimes the absence of words is the most effective form of communication.

Words or movements are not always necessary to express a message. Silence has a number of uses.

Silence can. . .

mean hostility, anger, and depression.

be soothing, showing empathy.

express concern and caring.

provide time to organize one's thoughts.

defuse tensions.

offer time for consideration of ideas or for interpretation.

provoke a response from the other person.

be a controlling device.

be a resistance to saying what should not be said.

Silence is a very powerful communication technique. At times, the physical presence of another person is all the reassurance and comfort that a person needs.

Active Listening

What is verbalized in communication is only one side of the coin. The other side is listening. Concentrate on improving your listening skills as you become an experienced staff member. You will experience many rewards from developing this skill.



Active listening is the act of hearing and responding both to the content and to the feeling of what is being said. Words are often a cover up of what people feel. Most of us have learned to use words to protect ourselves. Learn to listen for the feelings that are behind those words.

For example, in the statement: "I don't want my dinner," the content is simply the information stated about the speaker not wanting dinner. The feeling could be that the speaker is not happy about something, dislikes the food, or wishes to register a protest about something by not eating dinner.

Employing an active listening strategy, one would respond to the emotional content of the message. For example, one could respond to the feeling behind what was said by saying something like, "It sounds as if you're not happy with the food here," or "You must be upset about something."

Active Listening is an art. It is best defined as focusing on what is being said so that you will gain an understanding of what the individual needs and wants. Principles of Active Listening are as follows:

- Be silent – you cannot listen if you are talking or busy planning what you will say next.
- Use eye contact to show that you are paying attention.
- Use body language to show that you are attentive and interested.
- Use expressions like "go on", "uh huh" or "I see" to encourage further discussion by the person.
- Control your facial expressions. Show interest – not boredom.
- Focus on what the person says and does not say.
- Look at how the person is using body language.
- Do not be judgmental of the person's choice of words, expressions, or ideas.
- Reflect the person's thoughts and feelings back to him/her by restating what you are told. This will validate the consumer's feeling of being heard and assist in clarifying the message.
- Ask questions to clarify the information if you do not understand.

- Be sure you understand by restating the message and asking the consumer if you are correct.
- To get more information ask questions that begin with “how” and “why”. Do not use questions that will give you one-word answers or that can be answered with a “yes” or a “no.”
- Once you think you understand the message, clarify and summarize (provide feedback) what you have heard.

Some useful phrases for building understanding and receiving feedback are:

- “You seem really...” (Identify the feeling.)
- “From your point of view...”
- “If I understand what you're saying...”
- “I’m not sure I understood you, do you mean...?”
- “How do you feel about...?”

Active listening is a very effective communication tool. Using this listening strategy is helpful when you wish to convey that you are interested in what is being said, to show that you understand what the other person is saying and feeling, and to help the speaker explore all angles and come up with her/his own answers, and to encourage the other person to keep talking.

Active Listening Basic Do’s and Don’ts

- 1. Hold your own biases and prejudices in check.**
- 2. Concentrate on what is said.**
- 3. Turn down background noises.**
- 4. Put yourself in the consumer’s shoes – be empathetic.**
- 5. Do not try to do other things, such as write memo’s, while listening.**
- 6. Listen for what is not said.**
- 7. Identify emotional content of message.**
- 8. Do not jump to conclusions or give advice.**
- 9. Do not try to talk and listen at the same time.**

Communicating with Consumers

Each employee must foster a climate that creates better communication between all persons they will be working with. When a positive climate is created, communication flows freely. People feel able to discuss their feelings, needs, wants, and problems without being made fun of, criticized, or demeaned in anyway.

You can create such a climate by practicing the following principles:

- Everyone is listened to non-judgmentally, patiently, and respectfully.
- Emphasis is placed on being empathetic and supportive.
- The Sender is focused upon, without distraction, during communication.
- Disrespectful, humiliating, or aggressive behavior is not tolerated.
- Emphasis is placed on collaborative communication that empowers, rather than directive statements, which give orders.
- Information is shared on a “need to know” basis with the confidentiality of everyone’s information respected and recognized. Confidential information about a consumer should only be shared with other staff members if they absolutely **need-to-know** the information in order to do their jobs effectively.



NOTE: Health care and human service teams need to share essential, relevant information in order to ensure that the safety and effectiveness of treatment are maximized. The sharing of identifiable data on the grounds of a need-to-know should be limited to those who have a demonstrable need to know it as part of their role in providing care.

Staff should promote consumer communication in all its forms, including use of the telephone, writing letters, in-community visits and other approaches to maintain the consumer’s contact with significant others in the community. The communication capacity of some consumers will diminish over time if not stimulated.

Always keep in mind that all staff-to-consumer communication is privileged and confidential. Health care and human service workers must respect the privacy of communications with consumers, regardless of whether they are spoken or written.

Communicating with Other Staff Members

Staff-to-staff communication can be improved and made more effective where:

- Staff members communicate with each other about key situations and events so that crucial information is shared.
- Staff members emphasize team responses to situations and events and communicate accordingly.
- Policy and methods are formally discussed amongst staff and related information and ideas are shared.
- Consumer needs and capabilities are discussed and shared so that related services can be planned for and developed.
- Staff communicate mutual problems, dissatisfactions, and conflicts openly and regularly, and seek positive solutions that result in greater comfort and better care.

- Staff members communicate regularly to management or ownership, conveying problems, needs, and ideas for improvement.
- Each staff member owns responsibility for his/her own communication, communications errors, and need for communication improvement in the larger team.

Communicating With Your Supervisors

One of the least talked about communication areas is staff-to-supervisor communication. Staff members often need information, direction, support, or other input from their superiors. Staff may need to provide superiors with feedback that is unpleasant to hear. *It is nonetheless vital that you communicate regularly and openly with your supervisor.* To avoid conflict at such moments, use tact, patience, and objectivity. In solving problems, the effort should be directed at finding solutions, not toward blame. Remember your supervisor has a broader level of responsibility than you do, and must take into account the needs of all consumers and the behavior of many staff.

Communicate objectively and clearly with your supervisor and don't hesitate to ask for guidance and support. Such communication can be mutually helpful. Your supervisor needs to know of problems that you see first-hand in dealing with consumers.

Communicating With Family and Friends

Staff must attempt to develop regular communication with the families and friends of consumers to encourage engagement. Regular communication with families to urge their visitation and other involvement supports keeping consumers in touch with the larger community. Moreover, a consumer's family and friends can frequently provide valuable insights that will assist staff in working with that person. They might, for example, be able to clearly "translate" non-verbal communications, such as facial expressions, which may not be understood by others.



NOTE: While communication with family and friends is important, you cannot reveal personal and/or confidential information (even to family members) without the consumer's permission. Ask your supervisor for guidance if you are unsure about what you can discuss.

Communicating With Selected Consumers

The categories of individuals that follow are frequently encountered in home and community care. They also represent consumers who may often receive minimal conversation due to their special needs. Some of these people may seem almost invisible because of their inability to express themselves. Communicating with these people takes patience, practice, energy, and time. The results are well worth the effort.

1. **Communicating With a Person Who is Hard of Hearing**

You should always try to find out from the person his or her preference for communication. In addition to the information the person shares with you, here are a few other reminders:

- A. If the person wears a hearing aid and the hearing aid is not visible, find out if it is in the person's room, or somewhere else. Ask why the person is not wearing the hearing aid.
- B. If the person wears a hearing aid and still has difficulty hearing, check to see if the hearing aid is in the person's ear. Also check to see if it is turned on, adjusted, and has a working battery. If these things seem to be fine and the person still has difficulty hearing, find out when the person last had a hearing evaluation.
- C. Wait until you are directly in front of the person, have that individual's attention, and are close to the person before you begin speaking.
- D. Be sure that the individual sees you approach; otherwise your presence may startle the person.
- E. Face the person who is hard of hearing and be on the same level with him/her whenever possible.
- F. Speak in a low pitch voice. Sometimes a person can hear a man's voice or a lower pitch voice better than a female's voice.
- G. If you are eating, chewing, or smoking while talking, your speech will be more difficult to understand and the person will not be able to read your lips.
- H. Keep your hands away from your face while talking.

- I. Recognize that people with hearing deficits hear and understand less well when they are tired or ill.
- J. Reduce or eliminate background noises as much as possible when carrying on conversations.
- K. Speak in a normal fashion without shouting. Make sure that a light is not shining in the eyes of the hearing impaired person.
- L. If a person has difficulty understanding something, find a different way of saying the same thing, rather than repeating the original words over and over.
- M. Use simple, short sentences to make your conversation easier to understand.
- N. Write messages if necessary.
- O. Allow ample time to converse with a hearing impaired person. Being in a rush will compound everyone's stress and create barriers to having a meaningful conversation.

2. Communicating With a Person Who is Deaf

Communicating with people who are deaf may or may not be similar to communicating with the hearing impaired. Most people who are deaf communicate through American Sign Language. It is its own language. The Americans with Disabilities Act provides people with disabilities access to services and programs provided by the state or federal governments. Sometimes, a qualified sign language interpreter may be needed to ensure that communication is possible.

There are several possible strategies that you can use to communicate with someone who is deaf:

- A. Use sign language if you (and the person who is deaf) know how.
- B. Ask staff how they communicate with the deaf person. But keep in mind that the staff may not be communicating effectively or as required by law.
- C. Write messages if the person can read.
- D. Use a pictrogram grid or other device with illustrations to facilitate communication.

- E. Be concise with your statements and questions.
- F. Utilize as many other methods of communication as possible to convey your message.
- G. Allow sufficient time to communicate with the person without having to be rushed or under pressure.

3. **Communicating With a Person Who is Visually Impaired**

Although visually impaired people can still hear, there are adaptive measures that can aid communication. Always ask the visually impaired person what kind of assistance they would like before providing any.

The following suggestions are ways to improve communication with a visually impaired person:

- A. If you are entering a room with someone who is visually impaired, describe the room layout, other people who are in the room, and what is happening.
- B. Tell the person if you are leaving. Let him/her know if others will remain in the room or if she will be alone.
- C. When you speak, let the person know whom you are addressing.
- D. Ask how you may help: increasing the light, reading the menu, describing where things are, or in some other way.
- E. Say the person's name before touching them. Remember that touching lets a person know you are listening.
- F. Allow the person to touch you.
- G. Treat him/her like a sighted person as much as possible.
- H. Use the words *see* and *look* normally.
- I. Legal blindness is not necessarily total blindness. Use large movement, wide gestures, and contrasting colors if this will be helpful to the person.
- J. Explain what you are doing as you are doing it, for example: taking notes, looking for something, putting the wheelchair away.

- K. Describe walkways in routine places. Use sound and smell clues.
- L. Encourage familiarity and independence whenever possible.
- M. Leave things where they are unless the person asks you to move something.
- N. Provide written materials in Braille or large print whenever possible.

4. **Communicating With a Person Who Experiences Aphasia**

Aphasia is a total or partial *loss* of the power to use or understand words. It is often the result of a stroke or other brain damage. Expressive aphasics are able to understand what you say; receptive aphasics are not. Some victims may have a bit of both kinds of impediment. For expressive aphasics, trying to speak is like having a word "on the tip of your tongue" and not being able to remember it. Some suggestions for communicating with individuals who have aphasia follow:

- A. Ask the person and the staff how best to communicate. What techniques or devices can be used to aid communications?
- B. Be consumer and allow plenty of time to communicate with a person with aphasia.
- C. Be honest with the individual. Let her know if you can't quite understand what she is telling you.
- D. Allow the aphasic to try to complete her thoughts as she struggles with words. Avoid being too quick to guess what the person is trying to express.
- E. Encourage the person to write the word he is trying to express and read it aloud.
- F. Use gestures or pointing to objects if helpful in supplying words or in adding meaning.
- G. Use a picturegram grid. These are useful for "fill-in" answers to requests such as, "I need" or "I want". The person merely points to the appropriate picture.
- H. Use *touch* to aid in concentration, to establish another avenue of communication, and to offer reassurance and encouragement.

5. **Communicating With Persons With Alzheimer's or Related Disorders**

Alzheimer's Disease is a disease of the brain that causes a steady decline in memory. This results in dementia, which is the loss of intellectual functions (thinking, remembering, reasoning) severe enough to interfere with everyday life. Alzheimer's Disease affects 10 percent of people 65 years old and almost 50 percent of those who are 85.

Here are a few tips for talking with someone who has Alzheimer's or a related disorder (Source: Alzheimer's Association):

- A. *Speak slowly and clearly.*
- B. *Use short, simple, and familiar words.*
- C. Show that you are listening and trying to understand what is being said.
- D. Maintain eye contact.
- E. Encourage the person to continue to express thoughts even if he or she is having difficulty.
- F. Be careful not to interrupt.
- G. Avoid criticizing, correcting, and arguing.
- H. Be calm, supportive, and positive.
- I. Use a gentle, relaxed tone of voice.
- J. Use positive, friendly facial expressions.
- K. Always approach the person from the front, identify yourself, and address him or her by name.
- L. Break tasks and instructions into clear, simple steps.
- M. Ask one question at a time.
- N. Allow enough time for a response.
- O. Avoid using pronouns and identify people by their names.
- P. Avoid using negative statements and quizzing (e.g., "You know who that is, don't you?").
- Q. Use nonverbal communication such as pointing and touching.
- R. Offer assistance as needed.
- S. Don't talk about the person as if he or she wasn't there.
- T. Have patience, flexibility, and understanding.

6. **Communicating With Non-Responsive or Withdrawn People**

Communicating with non-responsive people is difficult for most people because you receive no feedback. You don't know if your message has been received or what the other person's reaction to it is. A non-responsive person seems incapable of giving a verbal or nonverbal response. These

may be people who are comatose or seem that way, who are withdrawn and don't acknowledge your presence, who seem to be completely in a world of their own, or for whom no effective method of communication has been found. Sometimes non-responsive people have shocked their visitors by saying a few words or by giving a clear response after weeks of no obvious response. Although there is no *one* correct way to communicate with these people, there are a few tips to remember:

- A. Be sure to communicate with non-responsive people. If a person is difficult for you to communicate with, other people may not visit that consumer either for the same reasons you have difficulty. These people are often the least visited, and thus receive the least stimulation. Therefore they may be among those individuals most in need of a visit.
- B. Be present for the person on a routine basis. If possible, hold the person's hand or give a pat on the arm while talking.
- C. If appropriate, try different kinds of sensory stimulation as well as different conversational topics to see if something strikes a chord of responsiveness in the person. You might bring music, a feather, a carpet square, or a bright picture to try.
- D. Always assume that the person can hear and understand what you are saying.

7. Communicating With a Person From Another Country or Culture

Maine traditionally has not been a very diverse state, but that is changing rapidly. Recent articles in local newspapers and magazines have highlighted the growth of diversity in Maine's city and towns. The chances are greater that you will encounter people from other countries or cultures during the course of your work in health care and human services. Thus, it is important for you to understand how people from other cultures can impact your work.

Nancy Summers highlighted many of the important issues in her workbook "Fundamentals of Case Management Practice" – published by Brooks/Cole.

"Each of us brings to any situation perceptions and attitudes that are influenced by our own culture. Our own ethnic group, family values, outstanding experiences, and cultural traditions all influence both the way we communicate to other people and what we believe other people mean when they use us. Often we are unaware of the extent to which these factors color our interactions with other people.

In addition, we do not usually take the time to understand that others may come from a culture that may differ from our own significantly. We may judge others' actions by the standard prevalent in our own culture. We may expect certain behaviors we believe is appropriate and become annoyed when we do not see that behavior. We may misunderstand the communication of others, leading to lost rapport and opportunities. This is dangerous when we have accepted the professional responsibility for giving assistance to other people.” (Summers, 2001, p. 73)

Summers highlights several obstacles to understanding people from other cultures:

- A. **Stereotypes** - preconceived notions or assumptions about how people from other cultures think or behave.
 - Example - “All Jewish people are thrifty”
- B. **Ethnocentrism** - using standards of conduct from our culture to judge the behavior of people from other cultures.
 - Example - Several years ago, a Danish tourist was arrested, searched, and jailed by police for leaving her 14-month-old child outside in a carriage while she had drinks in a New York City restaurant and bar. Her child was placed in foster care. Most New York residents thought the woman's behavior was negligent, but most parents in Denmark were astonished that the woman was arrested. In Denmark, it is common practice to leave children outside unattended.
- C. **Prejudice** – preconceived judgments or opinions about another person, group, or race based upon weak evidence, insufficient information, and/or little justification.

Make sure that you are aware of your own biases and prejudices. Be careful in your conversations with people from other countries and cultures to listen carefully and remain open to the differences that can exist. Not everyone will think or interact as you do or as you may expect. By working to see people as individuals, rather than as representatives of their culture or ethnic groups, you maximize the chances that you will truly understand their needs and concerns.

Methods of Communication

Communicating with People that Have Physical, Emotional, Cultural, and Social Impairments

Many individuals lack the ability to communicate even basic needs and wants. The inability to communicate with others can be devastating in terms of quality

of life. Communication allows a person to influence what happens in their environment by making their needs and wants known. It allows them to participate more fully in the daily activities of their community.

Think for a moment of some of the many reasons people have to communicate. Language serves many social as well as personal functions. Some common communication intents are:

- To comment on or draw another's attention to an object or event
- To attract attention to oneself
- To draw another person's attention for the purpose to starting conversation
- To acknowledge another person's communication
- To respond to requests for information from others
- To request desired objects and activities
- To request information
- To protest or reject an item or activity (say NO)

Now imagine not being able to do any of these things.

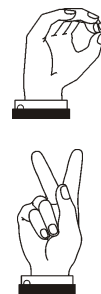
There are a variety of other means that non-speaking individuals can use to communicate. Direct service staff members need to understand the different types of communication systems available and how they function, so that they can communicate effectively with these individuals.

To communicate in most situations, people talk (use spoken language). However, on a daily basis people also use many other forms of communication. For example, you might wave to get the attention of a friend who is some distance away. In a noisy environment you might give directions using gestures. If you are having trouble describing an object or concept, you might use a picture to illustrate what you are trying to say.

1. **Common Communication Methods**

There are many types of communication methods in use:

- A. **Sign language.** Sign language is frequently used by people who are deaf. It consists of a series of hand signals that convey concepts or ideas from one person to another. The most common sign language used is called American Sign. It is taught in many Adult Education programs around the state. Sign language is very different from English. It does not use pronouns or words like "the" and "an". Since it is not a direct translation from English, it is better to think of Sign language as a foreign language with its own sentence structure and idioms.



Deaf people are not the only ones who use sign language. Many persons who are autistic or have no speech may use sign language to communicate. There are interpreters who can translate sign language when needed. Some people may develop their own personal version of sign language or hand signals to communicate certain things. When a specialized version of sign language is used, it is a good idea to create a book of signals to allow staff to accurately interpret what the individual's messages are and reply to them.

B. Pictures or Picturegraphs. People who cannot speak may also use communication cards or picture cards used. These are made and sold commercially but you can make your own if necessary. They are index cards with pictures of various objects on them such as a bed, lamp, glass, toothbrush, etc. The person can communicate by showing you the picture of what he wants.

C. Pencil and Paper: Persons who have lost their ability to speak after they have acquired language skills may communicate by writing notes. You may have used this method yourself if you had laryngitis and could not speak.

D. Computers: Varieties of computer software packages are available which assist with nonverbal communication. Some are programmed with a voice so that when the user pushes a certain button a verbal message is delivered. Different buttons will give different messages.

E. Magnetic Letters and Board: These allow the consumer to spell out a message by moving the letters on the board to spell words.

New advancements are being developed all the time that will allow persons without speech and/or hearing to communicate with others.

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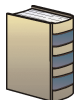
Module 5: Observation, Reporting, and Documentation



OBJECTIVES

After completing this module, you will be able to do the following:

- Describe the requirements concerning observation, reporting, and documentation;
- Describe the difference between objective and subjective observations;
- Relate observation skills to the collection of information about the consumer and how this relates to report writing;
- Describe the elements of good reporting;
- Identify situations that require an incident report to be written;
- Explain the function of documentation and why documentation is an important and necessary part of the job;
- Describe the characteristics of good documentation; and
- Describe the requirements concerning confidentiality.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Observation
- Objective observation
- Subjective observation
- Reporting
- Incident Reports
- Documentation
- Refusal of Care
- Confidentiality

Observation

Observing and reporting changes in the status of your consumers is extremely important. As a direct care staff member, you will spend more time with the consumers than anyone else. Therefore, it is likely that you will be able to detect minor changes in the condition of the consumer. The kinds of observations you should make are changes in any of the following:

- Vital signs
- Weight gain or loss
- Skin color, temperature, and moisture (bruises, cuts, lumps, rashes)
- Appetite
- Kind or level of activities (increase/decrease)
- Complaints of pain or discomfort
- Ambulation
- Breathing
- Mood or emotional state (sad/happy/ angry/ frustrated)
- Relationships with others
- Behavior
- Hearing and vision
- Self-care ability
- Symptoms such as headache; swelling anywhere on the body, but especially the feet and legs; sore throat; etc.

When making these **observations**, you are not simply looking at the individual. You are looking carefully for changes or symptoms and reporting them in detail to assist the health care professionals to determine what any changes in health status mean.

1. Objective versus Subjective Observations

There are two major types of observations: objective and subjective.

- A. An **objective** observation is one that is measurable or factual in nature - for instance, a consumer's temperature. When making objective observations, you are using all of your senses (seeing, hearing, smelling and touching) to collect detailed information about the consumer or consumer:



You use your sense of sight to observe things such as blood in the urine, swelling, or bruises.



You use your sense of hearing to observe things such as breathing, crying, or coughing.



You use your sense of smell to observe things such as urine and body odor.



You use your sense of touch to observe things such as lumps under the skin, changes in pulse rate, and the temperature of a consumer's skin.

- B. A **subjective** observation is a statement or complaint from a consumer about symptoms that only he/she can describe.

For example, statements such as “I have a headache” or “I feel nauseous” are observations that can only be described by the consumer.

Reporting

Once you have made your observations, it is important to **report** them promptly, completely, and accurately. Even if you verbally report these changes to your supervisor, you should also record them in the person's record.

- Be complete and detailed in your description of the observations.
- Do *not* draw conclusions or make assumptions. Report only the facts.
- If written, make sure that your report is neat and easy to read. Use proper grammar, spelling, and punctuation.
- Never use medical terms or abbreviations unless you are sure of the meaning, and it is appropriate for your audience. For example, you should not use a lot of medical jargon if you are writing a report that will be read by the person's family.

Incident Reports

Incident Reports are documents that record any unusual happening. The report will identify the specific nature of any incident or accident, note any persons who have witnessed the incident, record any follow-up or treatment that occurred, and identify persons notified, such as physicians, guardians, pharmacists, family members or caseworkers. Some typical situations in which an incident report would be made out are:

- consumer injury.
- consumer to consumer altercation or fight.
- visitor injuries.

- missing possessions.
- consumer elopement (consumer runs away).
- medication error (some facilities use special medication error forms for this purpose).
- staff to consumer altercations.

NOTE: Incident report forms should always be reviewed by the Administrator or his/her designee.

Documentation

Documentation of services and events in the person's care settings is a very important function. Staff members record this information in a patient, resident, or consumer record. This record is sometimes called a chart, a file, or a clinical record. The most important function of this record is to note the person's progress.

Records fulfill a number of useful roles in the health care and human service setting. Some uses of documentation include:

- To establish what actions were carried out by staff in a situation.
- To confirm what services have been delivered in order to justify reimbursement or payment by outside agencies [See Appendix for an example of a *Visit Report* – used in Home Care to document provided services].
- To enable staff to review or clarify processes of intervention used (tracking behaviors).
- To enable evaluation of service plan progress to determine if appropriate services are being delivered.
- To confirm compliance with state regulations governing elements of care.
- To provide data useful in determining a facility's (or home's) overall effectiveness.
- To have available information useful in providing continuity of care.
- To safeguard consistency of care over time and in changing environments.
- To document a person's progress and daily living skills.

Documentation or the recording of information is necessary to comply with state and federal regulations. Several key functions in the care process must be recorded. Some of these key functions are:

- Admissions contracts
- Assessments
- Service or Care Plans
- Incidents
- Appointments of guardians or powers of attorney
- Outside medical or other service interventions

- Care refusal.
- Medication Administration, if done by staff
- Advanced Directives

Although the federal government does not require specific documentation, records must be kept to prove to the Federal Government that the regulations are being met. For example, the facility must be able to show that it has a program to inform workers of hazardous chemicals in their environment. Similarly, any other areas covered under federal law and impacted in day-to-day operations, such as handicap access, freedom from discrimination or rights of privacy may require documentation as evidence of compliance. Failure to document can come back to haunt the agency should records be reviewed in an administrative hearing or other legal proceeding.



NOTE: It is crucial that you document promptly, accurately, clearly and correctly. Remember that an individual's file and daily progress notes are legal documents.

Use the following rules to guide your documentation:

- Record information in a timely manner.
- Make sure that your writing is neat and easy to read. Use proper grammar, spelling, and punctuation.
- Make entries in ink using a ballpoint pen, not a pencil or marker.
- Record the date and time of each entry.
- Sign each entry with your full name and title.
- Avoid using jargon or medical abbreviations – especially if you are uncertain of their correct meanings.
- Use only abbreviations approved by your facility or agency.
- Enter only specific, detailed statements, not vague suppositions about what occurred. Do not draw conclusions.
- Document a consumer's response to major incidents, refusals of care, medical or therapeutic services, and use of outside services.
- Write on every line of daily progress notes, and **do not** leave spaces or open lines. If part of the line is empty, draw a line through it.
- Never attempt to erase, "white out", or scribble over an entry. Draw a line through errors and initial them. Then, add the new information.
- Document or record only that care you provided to the person or that you participated in. Never record information or events about which you have only heard.
- Do not make entries for another employee, even if asked.
- Do not enter or refer to a consumer's name in another person's file. This is a violation of confidentiality. Use terms like roommate or other consumer.

- If you are describing what someone told you put his/her statement in quotes to indicate that it is the person's words and not your observation. Example: The consumer stated," John called me a witch".
- If you forget to record something, you can make a late entry. To use a late entry you will write the date you are actually recording the information. Below it, you will write " Late Entry for (date you are recording for)" Then, you will write your note following the guidelines above. Late entries should be used infrequently. **Charting is best done when the thoughts are fresh at the time of the occurrence.**

A consumer's personal file or chart may contain a range of documents pertaining to the individual, such as assessments, or service plans, health care notes, behavioral charts and reports from other providers.

Typical files or charts may contain entries on:

- Observed changes in a person's behavior or condition
- Dates and explanations of family, doctor, social worker, or other visits
- Incidents or accidents involving a consumer
- Consumer involvement in social or recreational events, in or out of facility
- Action taken on any element of the consumer's service plan
- Effectiveness of, impact of, or changes in the service plan
- Staff comments regarding the consumer's adjustment to his/her home environment or facility
- Consumer's refusal of any form of established treatment or intervention
- Errors in medication (if you are authorized to pass medication).

A note about refusal of care or refusal of treatment reports

If a consumer refuses some form of regular treatment, care, or medication, *consult with your supervisor*. He/she may ask you to complete a **refusal of care** or treatment form for the consumer.

On the form, you will record:

- What was refused and when it was refused.
- Why it was refused.
- Alternatives or substitute care offered.
- Explanation of why the particular care should be permitted by the consumer.
- Any persons, such as physicians, caseworkers, family members, or nurse consultants who have been notified.

There is a growing debate in the health care field about having the consumer sign refusal forms. In some situations, the consumer may be asked to sign the form indicating that he or she has received information about why the care or medication is important. This is done to show that the consumer made an informed choice. On the other hand, some do not require that the consumer

sign the form. Those facilities believe that asking the consumer to sign the form may be interpreted as a “threat”. You need to follow the policy of the facility you work at in this matter.



NOTE: It is always advisable for health care and human service workers to become familiar with the record keeping and documentation methods used in whatever setting they are working. You should always report to supervisors any changes from accepted practice that come to your attention.

Maintaining Confidentiality

All personal and medical records are **confidential**. The person receiving support services has the expectation that his/her privacy about care and other matters will not be shared with anyone. It is the job of each staff member to see that this right of privacy is upheld. The only people who are allowed to read a consumer's record are the consumer or his guardian, staff members in performance of their job, and state inspectors on official business. For anyone else to read the record, the consumer or guardian's permission must be obtained. Family members, friends, visitors, or others **do not** have the right to access these documents unless permission has been granted in writing. You should consult your facility or agency's policy on these issues.



6

Module 6: Health, Safety, and Fire Prevention



OBJECTIVES

After completing this module, you will be able to do the following:

- Describe the common causes of injury;
- Describe the general rules of environmental safety;
- Describe the proper techniques and equipment for lifting and moving people;
- Explain the basic concepts of fire prevention;
- Explain what to do in the event of a fire;
- Describe the safety precautions necessary when oxygen is being used;
- Explain what to do when you encounter workplace violence;
- Identify hazardous materials and explain how to handle them appropriately;
- Explain the principles of defensive driving;
- Explain basic infection control procedures and the importance of proper hand washing; and
- Explain the role of first responder.



VOCABULARY

After completing this module, you should know the meaning of the following words:

- | | |
|--|--|
| • Hypothermia | • Contagious |
| • Occupational Safety and Health Administration (OSHA) | • Other Potentially Infectious Material (OPIM) |
| • Fire Triangle | • Universal Precautions |
| • RACE | • Contamination |
| • Class A, B, and C Fire Extinguishers | • Engineering Controls |
| • PASS | • Work Practice Controls |
| • Material Safety Data Sheets (MSDS) | • Personal Protective Equipment |
| • Pathogen | • Housekeeping Measures |
| • Infections | • Asepsis |

General Safety

Health care and human service staff must act to protect the health and safety of persons in their care. Staff must be concerned with basic hygiene, freedom from electrical and environmental hazards, obstructions in normal travel ways, malfunctioning equipment, chemical hazards, and other similar sources of danger to consumers.

As a staff member, it is your responsibility to make observations as you go about your assignment. If there is a safety hazard, it is your job to report it to your supervisor, or as outlined in your agency's/facility's policy.

1. Falls

Falls are one of the most frequent injuries in residential and homecare settings. The dangers involved in a fall for older adults are well documented. Broken hips, legs and arms in the older population frequently result in an end to independence.



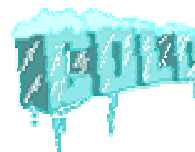
You should look for the following hazards:

- Frayed carpet and scatter rugs
- Loose tiles or lifted edges of linoleum
- Wet floors
- Cluttered hallways or paths
- Presence of ice or snow
- Lack of appropriate footwear
- Defective walkers, canes or other mobility equipment
- Poor lighting, including burnt out light bulbs – especially at night.
- Inadequate handrails on staircases.
- Pets that are underfoot

Some consumers take medications that can make them drowsy or dizzy. This can make it more difficult for them to navigate staircases and other hazardous areas in the home, such as bathrooms. Consumers who require assistance with ambulation may receive help from assistive devices, others in the home or the staff.

2. Hypothermia

Chilly air and blustery winds can be deadly cold, especially for older people who are at higher risk for hypothermia than are young adults.



Hypothermia is a below-normal body temperature - typically 96° Fahrenheit or lower. Surprisingly, hypothermia can threaten the health of older people in cool indoor temperatures such as 60°F to 65°F. As people age, they may lose their natural ability to keep warm in the cold. Inactivity, illness, weight loss, and certain medications make it even more difficult.

"Usually we think of hypothermia as something that happens to people outdoors," says Dr. Terrie Wetle, Deputy Director of the National Institute on Aging (NIA). "It is important to know that some older people may have a dangerous drop in body temperature inside their own home."

According to Dr. Wetle, older poor people are at an increased risk for hypothermia because they may keep indoor temperatures low to save on heating costs. Signs of hypothermia include any unusual change in behavior, confusion, sleepiness, clumsiness, slurred speech, and shallow breathing. The sure way to detect hypothermia is by taking a person's temperature. A temperature below 96°F will not register on many oral thermometers. If the temperature reading is at or below 96°F, call your local emergency medical service (911) immediately.

Hypothermia can be prevented. The PSS can help by:

- Making sure that the consumer is dressed warmly in layers of clothing even when indoors. Hypothermia can occur in bed, so make sure that the consumer wears warm clothing to bed and uses blankets.
- Serving hot foods and hot liquids to maintain the consumer's body temperature and keep warm.
- Making sure that the thermostat in the home is set at least between 68°F - 70°F in living or sleeping areas.
- If appropriate, suggesting fuel-assistance programs and home winterization programs. The local utility company or area office on aging will often have some sort of assistance program.

3. Burns

Most people associate burns with flames. In fact, burns are caused more often by liquids than by flames. Hot water is a great convenience in the home, but it can cause a serious burn quickly. It can maim or even kill. Very young children, people who are handicapped, and older people are particularly vulnerable to tap water burns.

Children cannot always tell the difference between the hot and cold-water faucets. They have delicate skin, and often cannot get out of hot water quickly. So they suffer hot-water burns most frequently.

Older people and people with handicaps are less agile and more prone to falls in the bathtub, and they may have less ability to sense when water is too hot.

HOT WATER CAUSES THIRD DEGREE BURNS:

- in one second at 156°
- in two seconds at 149°
- in five seconds at 140°
- in fifteen seconds at 133°.

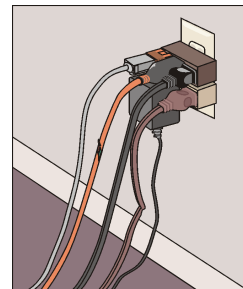
HOT WATER BURNS ARE 100% PREVENTABLE

- A. **Keep hot liquids out of the reach of children.** Babies - the most frequent victims of hot liquid scalds - need only a split second to grab a coffee cup, or bump a sipping parent's arm. Spilled hot coffee or tea, usually hotter than 160°, will cause severe injury. Toddlers can spill hot liquids by pulling at tablecloths, pot handles, and cooking appliance cords. They may be underfoot while someone is carrying pots around the kitchen. Protect babies or toddlers by placing them in a high chair or playpen while you are cooking.
- B. **Supervise children and older people in tub baths.** Young children are able to turn on the hot water by themselves. Older or handicapped people are prone to falling. They should never be left alone in the tub, even momentarily. The water should be no hotter than about 100° or warm to the touch. Remember that the water temperature feels cooler than it is if you are wearing gloves.
- C. **Check water heater thermostat level.** Most water heaters are set to heat water well above 140°, but a tap water temperature of 120° should be hot enough for washing clothes and dishes. Although many automatic dishwasher instructions suggest 140°, cleaning is usually satisfactory at much lower temperatures. Few people bathe at temperatures above 110°. If you believe the water is set too hot, contact your supervisor.

4. Electrical Safety

Electrical safety is another area of concern. Some of the appliances used by consumers may not be safe. The cords may be frayed or the plugs may contain bare wires. There are several things that you can do to reduce the risk:

- A. Inspect all items for frayed cords or damaged plugs before use
- B. Do not overload electrical circuits by plugging in numerous cords
- C. Report any unsafe items to the consumer and, if appropriate, your supervisor
- D. Only purchase or use items with a “UL” tag on them
- E. Do not attempt to repair electrical equipment yourself
- F. If an electrical item “smokes”, turn it off, unplug, and remove it
- G. Unplug countertop appliances when they are not in use.



5. Lifting and Moving

Many consumers are totally dependent on others for assistance with their activities of daily living (ADL), such as dressing, bathing, feeding, and toileting. Each of these activities involves multiple interactions with handling or transferring of consumers and could result in employee injury.

According to the Bureau of Labor Statistics in 1994, nursing facility workers suffer most injuries (51.2 percent) when handling consumers. Fifty-eight percent of their injuries are strains and sprains. While back injuries account for 27 percent of all injuries in the private sector, in nursing homes they account for 42 percent of all injuries. Of the 10 occupations with the largest number of injuries and illnesses, nursing assistants are exceeded only by truck drivers and non-construction laborers.

Potential risk factors for injuries when lifting and moving people:

- Overexerting. Trying to stop a consumer from falling or picking the consumer up from the floor or bed.
- Performing multiple lifts (more than 20) during your shift.
- Lifting alone or the lack of available staff to help.
- Lifting un-cooperative or confused consumers.
- Lifting consumers who cannot support their own weight.
- Lifting consumers who are heavy.
- Performing work beyond your physical capabilities.
- Moving an object or a consumer improperly.
- Moving consumers who are in confined spaces or awkward positions.
- Ineffective training of employees in body mechanics and proper lifting techniques.
- Not using proper equipment (or defective equipment) – such as Hoyer lifts, gait belts, and slippery slides.

Occupational Safety and Health Administration (OSHA) Guidelines for proper lifting/moving:

- Never transfer anyone when you are off balance.
- Avoid heavy work with spine rotated.
- Lift heavy loads close to your body.

- Avoid vertical "dead-lifts".
- Never risk over exertion with a consumer that is resistant; ask for assistance.
- Use team lifts and mechanical devices (such as Hoyer lift, gait belts, and slippery slides) when necessary (keep in mind that consumers over 150 pounds are always considered "heavy").
- Properly place and adjust equipment used to lift consumers.
- Always bring the consumer toward you, never away.
- Don't lift fallen consumers alone; consider mechanical assistance.



Fire Safety and Prevention

Fire safety is of enormous concern in health care and human services. An important part of fire safety is to insure that everyone knows what to do in the event of a fire.

There are several ways that health care and human service providers will try to be sure that staff and consumers are prepared for an emergency. Your role is to participate in these efforts so that you are ready to handle these situations.

You should:

- Know your agency's/facility's policy and procedures for fire emergencies.
- Know and practice your agency's/consumer's fire evacuation plan.
- Know the location of escape routes and how to remove people from fire areas.
- Know where to find the list of emergency phone numbers.
- Know the location of fire control equipment and how to use it.
 - a. Fire alarms
 - b. Fire doors and fire escapes
 - c. Sprinklers
 - d. Fire Extinguishers (see "What to Do in Case of a Fire").

Home-Based Care: If you work in a home setting, you should work out an evacuation plan with the consumer. You should also:

1. Know the exit routes from the home or apartment building.
2. Locate/test the smoke detectors in the consumer's home. Notify the consumer and/or family if a detector does not work.

3. Locate the fire extinguishers in a consumer's home. Make sure that it has not been discharged. Notify the consumer and/or family if the extinguisher does not work.

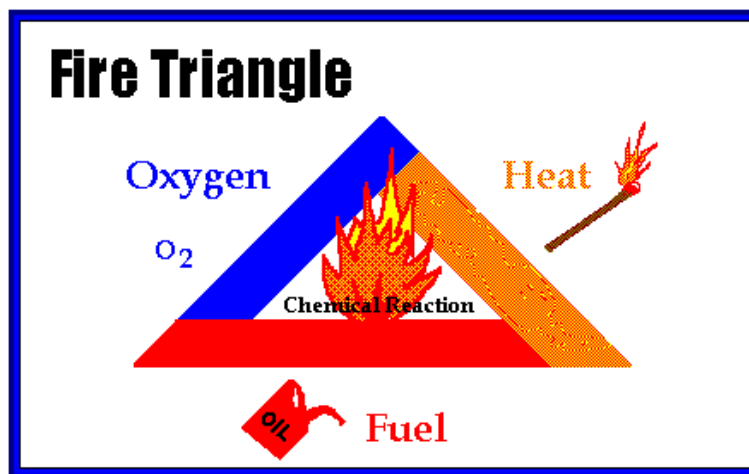
1. Fire Prevention

Fire prevention, at its most basic level, is based upon the principle of keeping fuel, oxygen, and heat sources separate.

Four things must be present at the same time in order to produce fire:

- Enough **oxygen** to sustain combustion.
- Enough **heat** to raise the material to its ignition temperature.
- Some sort of **fuel** or combustible material.
- The **chemical reaction** that is fire.

Oxygen, heat, and fuel are frequently referred to as the "**fire triangle**."



NOTE: An important thing to remember is that if you take any of these four things away you will not have a fire or the fire will be extinguished.

2. Common Fire Hazards

- Newspapers and books piled next to a radiator.
- Paint rags in a closet.
- Frayed electrical cords.
- Overloaded electrical circuits.
- Bare wires on lamp plugs.
- Smoking in rooms where oxygen is being used (see section on Oxygen Safety).
- Cigarette lighters and matches – especially if they are left where children and other unauthorized people can get access to them.
- Stove burners.

- Combustible chemicals, like cleaning fluids.
- Consumers smoking in bed.

Keep alert for all possible for hazards. Report any hazards immediately to your supervisor.

3. **What to do if a fire occurs**

If fire should occur, remain calm and remember the word **RACE**. That will help you to remember what to do:

R	R emove any consumers or people near the fire (make sure that you follow your agency's/facility's evacuation plan).
A	A ctivate the alarm and notify others that there is a fire.
C	C ontain or confine the fire by closing all doors and windows in the area.
E	E xtinguish the fire only if it is safe to do so.

4. **Using a fire extinguisher**

Most facilities and agencies require that all employees know how to use a fire extinguisher.

Fire Extinguisher Ratings

There are three different types or classes of fire extinguishers, each of which extinguishes specific types of fire. Newer fire extinguishers use a picture/labeling system to designate which types of fires they are to be used on. Older fire extinguishers used a label with colored geometrical shapes with letter designations. Both of these types of labels are shown below with a description:





Class A Extinguishers will put out fires in ordinary combustibles, such as wood and paper.



Class B Extinguishers should be used on fires involving flammable liquids, such as grease, gasoline, oil, etc.



Class C Extinguishers are suitable for use on electrical fires.

Multi-Class Ratings



Many extinguishers available today can be used on different types of fires and will be labeled with more than one designator (e.g. A-B, B-C, or A-B-C). This indicates that the extinguisher can be used on more than one type of fire.

If a situation requires you to discharge (use) a fire extinguisher, remember the word **PASS**.



Pull the metal pin on the upper handle. This pin keeps the handle from being accidentally pressed.



Aim the nozzle toward the *base* of the fire.



Squeeze the handle to discharge the extinguisher.



Sweep from side to side – making sure that you are still aiming at the base of the fire.

Oxygen Safety

During the course of your duties, you may encounter situations when a person is using oxygen.

Oxygen is present in the air around us, but sometimes a consumer will need more oxygen than is normally present in the air that we breathe. In these circumstances, a doctor will prescribe additional oxygen.



Supplemental oxygen is typically provided through wall outlets in hospital rooms, through oxygen tanks – such as the one pictured on the right, or oxygen concentrators (Note: if you are taking a Certified Nurses Assistant training program, you will learn more about the use of oxygen later in the course).

As noted earlier, oxygen is one of the three things needed for fire to start (see fire triangle). Special precautions need to be taken whenever more than the normal amount of oxygen is present in a room since extra oxygen can make things catch fire and burn more rapidly.

To prevent fires, you should observe the following safety rules for oxygen use:

- Whenever oxygen is used, a “No Smoking” sign should be placed on the door of the room and over the consumer’s bed. This alerts everyone that special precautions need to be taken.
- You should politely remind consumers or visitors not to smoke in the person’s room. Matches, lighters, and smoking materials (cigars, cigarettes, pipes) should be removed.
- Electrical equipment (electric razors, radios, toys, etc) should be closely monitored or removed from the room entirely to prevent sparks.
- Flammable materials such as alcohol, oils, and nail polish should be removed from the room.
- Wool and synthetic fabric should be avoided as they can create static electricity and cause sparks. The consumer and staff should wear cotton clothing (cotton gown, non-wool sweaters, cotton blankets).



Home Care consumers may also require supplemental oxygen. Make sure that you remind the consumer and family to use caution and to follow these safety rules when oxygen is being used.

Working with Hazardous Materials

As part of your work in health care and human services, it is likely that you will encounter hazardous materials. Hazardous and toxic substances are defined as chemicals that are capable of causing harm. In this definition, the term “chemicals” includes dusts, mixtures, and common materials such as alcohol, paints, soaps, cleaners, and fuels. Drugs are not considered hazardous materials.



To protect employees from hazardous materials, the Occupational Safety and Health Administration (OSHA) - requires chemical manufacturers, distributors, and employers to participate in a hazard communication program. The OSHA hazard communication standard works like this:

Chemical Manufacturers and Importers	Must determine the hazards of each product.
Chemical Manufacturers, Importers, and Distributors	Must communicate the hazard information and associated protective measures to customers through labels and Material Safety Data Sheets (MSDS).
Employers	<p>Must. . .</p> <ol style="list-style-type: none"> 1. Identify and list hazardous chemicals in their workplaces. 2. Obtain MSDS's and labels for each hazardous chemical, if not provided by the manufacturer, importer, or distributor. 3. Develop and implement a written hazard communication program, including labels, MSDS's, and employee training, on the list of chemicals, MSDS's and label information. 4. Communicate hazard information to their employees through labels, MSDS's, and formal training programs.

OSHA is a part of the United States Department of Labor. Its function is to protect the safety of workers on the job.

1. **Proper Labeling**

Containers of hazardous chemicals must be labeled, tagged, or marked with the identity of the material and appropriate hazard warnings. Chemical manufacturers, importers, and distributors must ensure that every container of hazardous chemicals they ship is appropriately labeled with information and with the name and address of the producer or other responsible party.

2. **Material Safety Data Sheets (MSDS)**

The MSDS is a detailed information sheet prepared by the manufacturer or importer of a chemical. Among other things, this sheet contains information that can help you to use the chemical safely:

- A. The physical and chemical properties of the chemical (what does it do?).
- B. The physical and health hazards (how can it hurt you?).
- C. Routes of exposure (how can the chemical enter your body?).
- D. Precautions for safe handling and use (how can I use it safely?).
- E. Emergency and first-aid procedures (what do I do if I someone is exposed?).
- F. Control measures (how do I prevent accidents from happening).

Using Cleaning Products Safely

When you work with chemicals on a daily basis, it is easy to forget just how dangerous these products can be. The tendency is to forget to treat them with the respect they deserve, and painful injuries are often the result. Cleaning products are a good example. Most people use cleaning products fairly frequently, at work and at home. But how many people actually bother reading the directions or product contents? How many people use rubber gloves or splash goggles?

As a staff member in health care and human services, you will use many different types of cleaning products. Many of these products will be potentially hazardous so it is important that you use caution when using them on the job.

The Soap and Detergent Association offers several tips (**Do's** and **Don'ts**) for using cleaning products safely:

DO

- READ AND FOLLOW LABEL DIRECTIONS for proper use, storage, and disposal. Call the toll-free number on the label for additional information.
- Store cleaning products away from food and where they are not accessible to young children or pets.
- Keep products in their original containers with their labels intact.
- Put cleaning products away immediately after using them. This will limit accessibility to young children and help prevent accidental spills.
- Keep buckets with cleaning solutions out of the reach of young children and pets.
- Properly close all containers, especially those with child-resistant caps.
- Ventilate areas where cleaning products are being used.

Don't

- Mix cleaning products. Products that are safe when used alone can sometimes create dangerous fumes if mixed with other products.
- Reuse an empty cleaning product container for any other purpose. The label instructions and precautions for the original product may be inaccurate if used for a different product.

Read the label! Labels on cleaning product packages contain important information about products and their safe and effective use. They typically include the following information:



For more information about using cleaning products safely, visit the health and safety section of The Soap and Detergent Association website: <http://www.sdahq.org/health/safe/>

Preventing Accidental Poisoning

The following information was obtained from the American Association of Poison Control Centers. Used with permission.

1. What is a poison?

A poison is any substance that can cause harmful effects in the body. Millions of people are unintentionally poisoned every year, and children under the age of six are at the greatest risk.

2. Most Dangerous poisons

- Medicines, including iron pills
- Cleaning products that can cause burns: drain opener, toilet bowl cleaner, oven cleaner, rust remover
- Antifreeze
- Windshield washer fluid
- Hydrocarbons: furniture polish, lighter fluid, lamp oil, kerosene, turpentine, paint thinner
- Carbon monoxide
- Pesticides
- Wild Mushrooms

3. Important Checklist for a Poison-Proof Home

- ☐ Keep all poisons and medicines in their original, labeled, child-resistant containers.

- ☐ Lock poisons and medicines out of the reach of children.
- ☐ Be as careful with non-prescription medicines as you are with prescription medications. To avoid confusion, do not refer to medications as “candy” or take them in front of children.
- ☐ Keep purses and diaper bags out of children’s reach. Also be aware of visitor’s purses and suitcases.
- ☐ Never leave children alone with household products or medications. If you are using a product, take a child with you when stopping to answer the telephone or the door. Most poisonings occur when the product is in use.
- ☐ Return household and chemical products to safe storage immediately after use.
- ☐ Know which plants in and around your home can be poisonous, and keep them away from your children.
- ☐ Take the time to teach children about poisonous substances.
- ☐ Keep the number of your poison control center on or near your telephone.

4. What to do if a poisoning occurs

- Stay calm and notify your supervisor.
- Immediately call your poison control center and have the following information ready:
 - a. The person’s condition, age, and weight.
 - b. Product containers and bottles.
 - c. Time that the poisoning occurred.
 - d. Your name and telephone number.
- Follow the instructions that the poison center gives you.

If you have any questions or would like more information about poison prevention, contact your local the poison center:

Northern New England Poison Center

Maine Medical Center
22 Bramhall Street
Portland, ME 04102

Emergency Phone: 1-800-222-1222; (877) 299-4447 (TTY/TDD)

FAX:(207) 773-8546

Workplace Violence

“The prevention of workplace violence has emerged as an important safety issue in today's workplace. Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the workplace.” [OSHA]

In 1993, the Bureau of Labor Statistics showed more assaults occurred in the health care and social services industries than in any other:

- 64% of the nonfatal assaults occurred in nursing facilities, hospitals, and establishments providing residential care and other social services.
- 27% of these injuries occurred in nursing facilities.
- The cause of injury in 45% of these cases was the consumer.

Employee Involvement

You can do your part to reduce workplace violence by:

- Understanding and complying with the workplace violence prevention program and other safety and security measures.
- Example: knowing how to protect yourself by leaving an area or threatening situation.
- Participating in any employee complaint or suggestion procedures covering safety and security concerns.
- Promptly and accurately reporting of violent incidents.
- Taking part in continuing education programs that cover techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discussing appropriate responses.
- Discussing concerns with your supervisor.

Whenever you feel unsafe at work or in a consumer's home, you should leave immediately, go to the nearest phone, and report this to your supervisor. Your safety should be your primary concern. The consumer's safety in these special circumstances will be your supervisor's concern.

Driving Safety

The following information was adapted from Cyberdriveillinois – a public resource for drivers developed by the Office of the Secretary of State – State of Illinois.

1. Alert Driving

A driver must concentrate on the road and drive defensively.

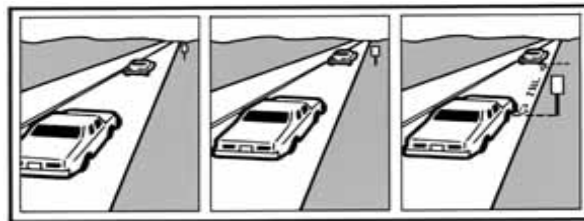
- A. **CONCENTRATION:** Operating a vehicle safely demands that the driver concentrate on driving. The person should be rested, calm and not under the influence of alcohol or other drugs.

One of the greatest hazards of roadway driving is drowsiness or “highway hypnosis.” Lack of sleep or fatigue impact your ability to safely drive your

vehicle. When taking a long trip, avoid drowsiness by stopping frequently to drink coffee, exercise, or nap. Exercise your eyes by reading road signs or shifting the focus of your eyes to different parts of the roadway. Make sure you are properly rested.

- B. **DEFENSIVE DRIVING:** Plan ahead for the unexpected. Always be prepared to react to the other driver. Do not expect the other driver to do what you think he or she should do. Do not think you know what he or she is going to do. If you cannot avoid a crash, remain calm and try to choose the least dangerous situation. For example, running into a ditch is less dangerous than a head-on collision. Also, your chances of survival are greater if your vehicle is in good mechanical condition.

C. VEHICLE FOLLOWING DISTANCES



TWO-SECOND RULE: Following a vehicle too closely is called “tailgating.” Use the two-second rule to determine a safe following distance. Select a fixed object on the road ahead such as a sign, tree or overpass. When the vehicle ahead of you passes the object, count “one-thousand-one, one-thousand-two.” You should not reach the object before you count to one-thousand-two. If you do, you are following too closely. Most rear end collisions are caused by the vehicle in back following too closely.

The two-second rule also applies to your speed when you are on a good road and during good weather conditions. If the road and/or weather conditions are not good, increase your distance to a four or five-second count. If you are being tailgated, move to another lane or slowly pull off the road and allow the vehicle to pass.



Two-Second Rule		
Vehicle Speed	Approximate Feet Vehicle Will Travel in 1 Second	2 Second Rule Distance
25 m.p.h.	37 feet	74 feet back
35 m.p.h.	52 feet	104 feet back
45 m.p.h.	66 feet	132 feet back
55 m.p.h.	81 feet	162 feet back

2. Vehicle Speed

- A. **MINIMUM AND MAXIMUM SPEEDS:** You should use common sense when driving. Driving too fast or too slowly may create a dangerous situation. Regardless of the posted speed limit, weather and traffic conditions may make it necessary to drive more slowly. However, driving too slowly can also be dangerous. Your speed should be adjusted for the conditions and match the flow of traffic, as long as it does not surpass the maximum posted speed.
- B. **STOPPING:** The ability to stop your car safely should be considered when deciding your speed. You should consider the following:
- How quickly you can react physically and mentally.
 - The type and condition of the roadway. It will be more difficult and take longer to stop on wet asphalt.
 - The kind of tires you are using and the condition of their tread. Large, wide tires with good tread will stop a vehicle faster than small, narrow tires with little tread.
 - The type, condition, and adjustment of your brakes.
 - The direction and speed of the wind. A strong tail wind can make it very difficult to stop.
 - Vehicle design, weight distribution, suspension and shock absorbers.

3. Weather Conditions

Weather can create a driving hazard. Special care must be taken in fog, rain, high winds, and winter driving conditions.

- A. **FOG:** It is best not to drive in fog. However, if you must drive in fog, take the following precautions:
- Slow down. If you see headlights or taillights, slow down even more. A driver may be driving in the center of the roadway or may be stopped or barely moving.
A yellow car is shown driving on a road in thick fog. The car's headlights are on, and the fog is depicted as a dense, greyish-blue mist.
 - Drive with your headlights set on dim, or use fog lights.
 - Do not overdrive your headlights. Stay within the limits of your vision. You may have to stop suddenly. If the fog is too dense, pull off the roadway and stop. Do not drive at five or 10 miles per hour.
 - Use your turn signal long before you turn and brake early when you approach a stop to warn other drivers.
- B. **RAIN:** When rain begins to fall lightly, water, dust, oil, and leaves cause the roadway to become slippery. When this happens, increase your following distance. Take special care on curves and turns and while braking. Your headlights must be on when operating your wipers. Parking lights are not acceptable.
A blue square icon with a white cloud, a yellow lightning bolt, and blue raindrops.
- When rain begins to fall heavily, your tires may “hydroplane.” This means the tires are riding on a layer of water and not on the roadway. Avoid

hydroplaning by slowing down. If you skid while hydroplaning, try to regain control of the vehicle. Otherwise, release the accelerator and ride out the skid.

- C. **HIGH WINDS:** Wind can be a difficult problem for all drivers. Wind is especially difficult for drivers of trucks, recreational vehicles, campers, and trailers-in-tow. In high winds, you should reduce your speed and make steering corrections when you go from a protected area to an open area and when meeting large vehicles such as trucks and buses. Heavy rain or sleet often accompanies high winds. You should be alert to wet or slippery areas and plan for those conditions.



- D. **WINTER DRIVING:** Winter is the most difficult driving season due to many reasons, including ice, snow, lower temperatures and fewer daylight hours. When driving in winter conditions:



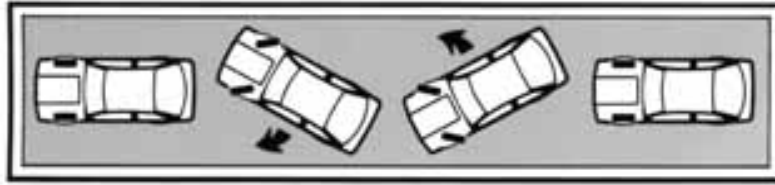
- i. Drive slower and increase your following distance. Roadway conditions may vary depending upon the sun, shade, or roadway surface.
- ii. Remove all snow and ice from your vehicle. Clear all windows, and do not start driving until your windshield is defrosted and clear. Be sure you have non-freezing windshield washer liquid and that your headlights and taillights are visible.
- iii. Be sure your vehicle is maintained properly. Lights, brakes, windshield wipers, defrosters, radiator, and other parts should be in good working order.
- iv. Use snow tires and/or chains (where allowed). Snow tires give you extra traction, and chains increase safety on snow or ice packed roads. Neither tires nor chains allow you to drive on bad roads at normal speeds.
- v. Start slowly. Gentle braking, in slow, steady strokes, helps you find out how much traction you have. Begin braking early when you come to an intersection or a stop.
- vi. Approach bridges, shaded spots, overpasses and turns slowly. They may remain icy after the rest of the roadway is clear and dry.
- vii. Plan your winter driving. Carry a blanket, food, and other survival equipment, such as a shovel, in your vehicle in case you become stranded. If you become stranded, remain in your vehicle. Run your engine only for brief times, and open your window to prevent carbon monoxide poisoning. Make sure your vehicle tailpipe is free of snow and debris.

4. **Special Driving Situations**

Just as weather and equipment affect your safety, other driving situations also require extra caution. These include:

- A. **HIGHWAY DRIVING:** Expressways, toll roads, turnpikes, and freeways are fast, multiple-lane roads. The maximum speed limit is 55 or 65 miles per hour. Here are some tips for safe driving on expressways:
- i. **GETTING ON HIGHWAYS:** When entering an expressway, you will usually find a speed-change lane. This lane allows you to gain the speed necessary before merging. You should signal and look for an opening in the traffic, match traffic speed and merge with traffic when safe.
 - ii. **GETTING OFF HIGHWAYS:** Exits may be on the right or left. Be sure to be in the correct exit and speed-change lanes. Signal your intent then slow down to make your exit in the speed-change lane.
 - iii. **DRIVING ON HIGHWAYS:** You should be especially alert when driving on highways. Speed and traffic volume are major concerns. Remember:
 - Check your rearview and side mirrors before changing lanes.
 - Use your turn signals when making lane changes.
 - Go to the next exit if you missed yours. Backing up on highways is against the law.
 - Do not follow too closely. Allow plenty of distance between you and the car ahead.
 - The right lane is for slower traffic. The left lane is used for faster traffic and for passing.
 - Do not stop on the highway. Pull off the road if you have a problem. Lift your car's hood and turn on your hazard flashers. Do not walk along the highway.
- B. **NIGHT DRIVING:** Night driving is difficult because things may appear differently than in daylight. Also, glare from lights may interfere with vision. Courtesy and common sense should be used when driving at night. Remember:
- Never overdrive your headlights. Always keep them clean and aimed properly. Use them at dusk and dawn. Bright lights must be dimmed 500 ft. before meeting an oncoming vehicle or 300 ft. before passing a vehicle.
 - If streetlights cause a lot of glare, dim your dashboard lights and use your sun visor. Avoid using any other light inside your vehicle.
 - Roadway signs are more difficult to see at night.
 - Use edge lines and centerlines of the roadway as guides.
 - Do not stop on the roadway. If you must stop, carry and use a red warning light.
- C. **CURVES:** Slow down before beginning the curve. Do not brake suddenly as this may cause skidding or locked wheels. Never drive over the centerline.

- D. **HEAD-ON APPROACHES:** When a vehicle is approaching head-on in your lane, slow down immediately. Pull over to the right and sound your horn.
- E. **SKIDDING:** Skidding occurs when tires lose traction. If you skid, ease off the gas pedal or brakes. Steer into the direction of the skid until you feel you have regained traction and then straighten your vehicle.



- F. **DRIVING OFF THE PAVEMENT:** If your wheels drift off the pavement onto the shoulder, grip the wheel firmly, ease your foot off the gas pedal, and brake gently. After checking for traffic behind you, gently steer back onto the pavement. Do not jerk your wheel to correct your steering. This may cause you to drive into oncoming traffic.
- G. **FIRE:** If smoke appears, pull off the road. Turn off the engine, move away from the vehicle, and call the fire department. Vehicle fires can be very dangerous. Do not fight the fire yourself.
- H. **WATER ACCIDENTS:** If your vehicle runs off the roadway into water but does not sink right away, try to escape through a window. Because of differences in water pressure, you may not be able to open your car door. If your vehicle does sink, move to the back seat area where an air pocket usually forms. Take a deep breath and exit from a rear window.
- I. **CELLULAR PHONE USAGE:** When using your cellular phone while driving, always remember your number one responsibility is driving. If you do use a cellular phone, take the following precautions:
- Always assess traffic conditions before calling.
 - Be familiar with the phone's keypad – use speed dial if possible.
 - Place calls when stopped, or have a passenger dial.
 - Ensure phone is within easy reach.
 - Use speaker phone/hands-free device.
 - Avoid intense, emotional, or complicated conversations.
 - Avoid talking on phone in congested traffic or bad weather.
 - Pull off road to dial or complete a conversation.





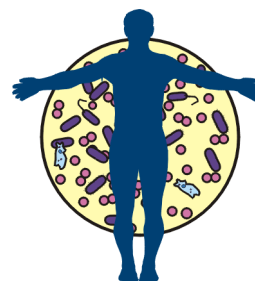
NOTE: Before transporting a consumer using their car, make sure that their insurance policy will cover you if an accident occurs (often, this will involve a call to your supervisor).

Consumers transported via car should be supervised at all times.

Basic Infection Control

The world is filled with germs called bacteria and viruses. Bacteria and viruses that cause disease (abnormal functioning in your body) are called **pathogens**.

Pathogens invade the cells of your body and cause **infections**. In many cases, infections can result in symptoms such as headache, upset stomach, runny nose, etc. An infection is considered to be **contagious** if it can be spread from one person to another.



In order for contagious germs to be spread from one person to another, three things must happen:

1. Germs must be present in the environment, either through a person carrying the germ or through infectious body fluids, such as discharge from the eye, nose, mouth, or digestive (gastrointestinal) tract; in the air; or on a surface.
2. A person who is not immune to the germ must come in contact with or be exposed to the germs.
3. The contact or exposure must be in a way that leads to infection.

As a health care and human service worker, you may provide services to people with long-term illnesses such as hepatitis and AIDS. Consequently, you could be exposed to blood and **other potentially infectious materials (OPIM)** as part of your daily tasks. Workplace exposures are rare, but you must be prepared.



1. Preventive Measures

Your risk of exposure to blood and other potentially infectious materials can be reduced by using measures such as Universal Precautions, engineering controls, work practice controls, personal protective equipment, and housekeeping measures.

A. Universal Precautions

The single most important measure to control the transmission of disease is to treat *all* human blood and other potentially infectious materials as if they were infected. Application of this approach is referred to as



Universal Precautions. Blood and other infectious materials from all consumers should be considered as potentially infectious materials. These fluids cause **contamination**, defined as, "the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface."

Methods of Control

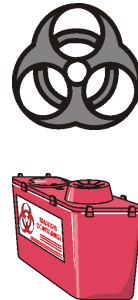
Workplace methods of control are the primary methods used to control the transmission of disease. Personal protective clothing and equipment also are necessary when exposure to blood-borne pathogens remains even after instituting these controls.

B. Engineering Controls

Engineering controls reduce employee exposure in the workplace by either removing or isolating the hazard or isolating the worker from exposure. Self-sheathing needles and special containers for contaminated sharp instruments are examples of engineering controls.

Engineering controls that apply to health care and human service workers include, but are not limited to, the following:

- i. Use puncture-resistant, leak-proof containers to store potentially infectious materials.
- ii. Use puncture-resistant, leak-proof containers, color coded red or labeled with a Biohazard symbol to discard contaminated items such as sharp instruments, broken glass, or other items that could cause a cut or puncture wound. Used needles should *never* be disposed of in household garbage or trash.



C. Work Practice Controls

Work practice controls reduce the likelihood of exposure by altering the way a task is performed. All procedures involving blood or OPIM must be performed in a way that will minimize spattering, splashing, spraying and the generation of droplets. Safe work practices include, but are not limited to, the following:

- i. Do not eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses in areas of occupational exposure.
- ii. Do not store food or drink in refrigerators or other locations where blood or potentially infectious materials are stored.
- iii. Wash hands when gloves are removed and as soon as possible after skin contact with blood or other potentially infectious materials.
- iv. Never recap or bend needles by hand.

D. Personal Protective Equipment (PPE)

In addition to instituting engineering and work practice controls, OSHA regulations require that personal protective equipment also be used to reduce worker risk of exposure.

The use of **personal protective equipment** helps prevent occupational exposure to infectious materials. Such equipment includes gloves, gowns, masks, and laboratory coats. Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or to reach your work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes. Under the standard, employers must provide personal protective equipment at no cost to the employee.

i. **Gloves**

Wear gloves when it is reasonable to think that you may have hand contact with blood, other potentially infectious body fluids, mucous membranes, and non-intact skin. Wear gloves when you handle or touch contaminated items or surfaces. If the surface is wet, put on gloves.



Always check your gloves for holes or other damage before using them. Do not reuse gloves. If a glove is damaged, don't use it! If you are allergic to certain glove materials, such as latex, your employer is required to provide you with gloves that you can safely wear.



NOTE: Ornate jewelry is a harbor for bacteria and should be removed before putting on gloves.

Gloves should be made of latex, nitril, rubber, or other materials that keep out water. You can use two gloves (double gloving) if the material seems thin or is easily broken. If you know that you have cuts or sores on your hands, cover them with a bandage or similar protection as an additional safety measure before putting on your gloves. Intact skin should be your first line of defense.

Remember – gloves only protect you from basic contamination. Make sure that you wash your hands after every use.



NOTE: In recent years, many health care and human service workers have developed sensitivity (allergies) to the latex found in most protective gloves. If you notice any skin irritation or itching after wearing latex gloves, ask your employer to switch to a non-latex alternative. If left untreated, some people can develop severe (life threatening) allergic reactions to latex.

ii. **Gowns and masks**




Because blood borne pathogens can be transmitted through mucus membranes, it is sometimes important to protect all areas of your body them. Use gowns and/or masks anytime you might splash or vaporize contaminated fluids. Splashing could happen while you are cleaning up a spill or providing first aid.



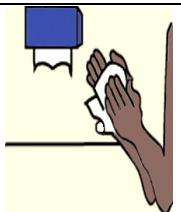
iii. **Hand Washing**

Hand washing is the *single most important* thing you can do to prevent infection. PROPER hand washing is critical for three reasons:

- It helps protect the consumers from whatever germs you are carrying.
- It helps to protect you from whatever germs the consumer is carrying.
- It prevents the infection from spreading.

You should use the following steps every time you begin to provide care for a person, as well as when you finish caring for them.

	Completely wet your hands
	Apply soap
	Scrub under your nails with a clean nailbrush

	Rub hands vigorously for at least 10-15 seconds as you wash them. Pay attention to back of hands, wrists, between fingers and under fingernails
	Thoroughly rinse your hands well under running water
	Dry your hands with a disposable paper towel or a clean towel. To minimize chapping (reddening, roughening or cracking of skin) of hands, pat dry rather than rub them. Electric hand driers may also be used. Turn off the tap with a paper towel, if applicable. Do not share towels with anyone else.

When to Wash Your Hands

- Before and after contact with consumers.
- After using the toilet.
- After removal of gloves and/or other protective clothing.
- After contact with any wastes, body fluid or contaminated items.
- Before eating.
- Before preparing food.
- After blowing nose, sneezing, etc.
- After cleaning an area.
- After smoking.

E. Housekeeping Measures

Housekeeping Measures involves cleaning, laundry, disposal of regulated wastes, and other practices that protect you from being exposed to pathogens. You should follow your employer's written schedule for keeping your work area clean and sanitary. In the home, you can assist consumers in keeping their living area clean.

- Clean all equipment and working surfaces as soon as possible after contact with blood or potentially infectious materials. This is especially important in the kitchen and bathroom.
- Remove contamination from work surfaces with an appropriate disinfectant.
- Inspect and decontaminate all bins, pails, cans, and similar containers that will be re-used on a regular schedule.
- Remove and replace plastic wrap, aluminum foil, or other protective coverings when they become contaminated, or at the end of the work shift if they might have become contaminated during the shift.

- If broken glass might be contaminated, clean it up using a brush and dustpan, tongs, or forceps. Do not pick up possibly contaminated broken glass with your hands!
- Separate clean and dirty laundry
- You may be asked by your employer to double-bag particularly contaminated laundry items, such as those with blood.

i. **Decontamination**

Use either:

- A decontamination solution of a quarter cup of household bleach (Clorox, for example) added to one gallon of water.
- Lysol or another disinfectant.

If you are cleaning up a blood spill, carefully cover the spill with rags or paper towels. Then pour disinfectant solution over the rags or towels and let it sit for ten minutes. If you are cleaning contaminated equipment or other objects, leave the disinfectant in place for at least ten minutes before you continue cleaning.

■ **Asepsis**

The purpose behind all of these efforts (hand washing, housekeeping, and decontamination) is **Asepsis** - the maintenance of a germ-free work and living environment. The goal of asepsis is to:

- Reduce the amount of pathogens in an area.
- Minimize capacity of a situation to create infection.
- Remove any invading organisms through cleaning, decontamination, and disinfection.

ii. **Response to Exposure**

If you have been exposed without protection:

- Wash the exposed area thoroughly with soap and running water. Use non-abrasive, antibacterial soap if possible.
- If blood is splashed in your eye, nose, or mouth, flush the affected area with running water for at least 15 minutes.
- Tell your supervisor about the incident right away and fill out an incident report. Make sure that you follow your employer's exposure plan.

If an emergency involves blood or potentially infectious materials body fluids and you have not yet been exposed, use Universal Precautions. Try to minimize your exposure by wearing gloves, splash goggles, and other barrier devices.

Basic First Aid

All of the information in this first aid section was adapted from the Irish Emergency Ambulance Services Resource (IEASR). Used with Permission.

You should not use this first aid information as a substitute for a complete first aid course. It is only intended as an information guide so you know a little more about this subject. Your role is as a “first responder.” Thus, your goal is to *Check, Call, Care* until help arrives. Your agency/facility nurse or a physician may instruct you to take certain measures if they deem appropriate based on their professional judgment. However, you may not independently make medical or nursing judgments. Your observations are important.



Steps to take in every emergency (Check, Call, and Care):

1. **Check** the scene and the consumer. Look for clues as to what happened. Check the consumer for consciousness, breathing, pulse, and bleeding.
2. **Call** for help. Call your supervisor, a licensed nurse, doctor, or 911 (your local rescue).

When calling for help, provide the following information:

- Exact location
- Telephone number
- Your (the caller's) name
- What Happened
- Number and approximate age of consumer
- Condition of consumer
- What help is being given

DO NOT HANG UP UNTIL THE EMERGENCY STAFF MEMBER TELLS YOU TO.

3. **Care** Give appropriate care to the victim, according to the emergency, as instructed by either a nurse, a doctor or emergency personnel, until trained help arrives to give first aid or transport to a medical facility.

+ Anaphylaxis

Anaphylaxis is a serious and rapid allergic reaction to a substance (food or medications) or insect bites and stings. If severe enough this condition can kill. Allergic reactions that occur almost immediately tend to be the most severe.

Causes:

- *Wasp and bee stings*
Check for faintness, breathing difficulties, rashes or swelling on a part of the body that has not been stung.
- *Exercise*

Exercise can cause reactions in some people and also exercise after food has been consumed.

- *Foods*
Especially nuts; some kinds of fruits like bananas, avocados, kiwi fruit, figs, oranges; vegetables including potatoes and tomatoes. People may get anaphylaxis from fish and some spices.
- *Drugs and Medications*
Penicillin's, anesthetic drugs, aspirin and other painkillers.
- *Latex*
Mainly latex gloves, condoms, and medical products, but also in many things encountered in daily life. Sufferers are nearly always health care or food preparation workers who have occupational contact with latex.
- *Unknown*
Some sufferers have unexplained attacks where no cause is found.

Check:

Signs and Symptoms:

- An itchy rash.
- Faintness and unconsciousness this is due to very low blood pressure.
- Swelling.
- Swelling in the throat, causing breathing and swallowing difficulties
- Asthma symptoms.
- Vomiting.
- Abdominal pains, diarrhea, and cramping.
- Swelling or tingling feeling in the lips or mouth.

Call:

You should immediately call a licensed nurse, doctor, or an ambulance (**911**) and report your observations.. Anaphylaxis is a life threatening condition.

Care:

Follow instructions of a licensed nurse, doctor or emergency personnel.

✚ Asthma

Asthma is a condition in which the muscles of the air passages go into spasm, making breathing difficult and resulting in a wheeze. Attacks may be triggered off by an allergy to dust, pollen, many other common substances, by over exercise or by nervous tension. Regular asthma sufferers usually carry their own medication in case of attack.

Check:

Check the consumer's breathing.

Call:

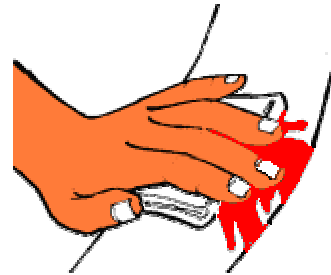
If the consumer is having difficulty breathing, call a nurse, physician or 911 and report your observations.

Care:

1. Reassure and calm the individual.
2. Advise the consumer to sit down, lean slightly forward, resting on elbows on a support such as a table.
3. Ensure a good supply of fresh air.
4. If appropriate, allow the individual to take his/her own medication as prescribed by a doctor.

+ Bleeding

The principle of controlling blood loss is to restrict the flow of blood to the injured part by pressure and elevation. Wash your hands and put on gloves or another barrier to protect your skin from blood exposure and to prevent infection.

**Check:**

Cuts, scratches and scrapes. Mild to moderately bleeding cuts and scrapes usually stop bleeding if covered with a dry dressing and pressure is applied firmly. A course of tetanus injections may be necessary if the consumer has not had an updated shot in the past ten years. Check the consumer's tetanus record.

Call:

Moderate to severe bleeding.

If bleeding is caused by more than a minor cut or scrape, call a licensed nurse, physician or 911 immediately. Report your observations to the health care professional. CNAs must report all injuries.

Care:

1. *Put on gloves if possible.* Always protect your skin from blood exposure by wearing gloves or placing a barrier between you and the area that is bleeding. Wash your hands thoroughly after using gloves or any barrier item.
2. Apply a clean dressing to the wound with firm, constant pressure, which should be held for up to twenty minutes.
3. Inform the health care professional if there is a foreign body (item) in the wound, such as glass. If a foreign body is present, you may be instructed to apply pressure alongside. Do not remove the item.

Hemophilia

Hemophilia is a condition where the blood is unable to clot without an injection of serum. Hemophilia sufferers usually carry an identity card or bracelet, and need

immediate medical attention, for even apparently minor injuries. Call licensed nurse, physician or 911 immediately.

✚ Bites, Animal and Human

Check:

Check for broken skin.

Call:

Call a licensed nurse or physician and report your observations. Follow instructions.

Care:

If severely bitten, seek medical help (i.e. call an ambulance).

Rabies

Rabies is a potentially fatal condition spread by the saliva of infected animals. If you suspect the bite has come from a rabid dog, make sure the consumer gets immediate medical help.

✚ Burns and Scalds

Burns are injuries to body tissues caused by heat, chemicals or radiation. Scalds are caused by wet heat, such as steam or hot liquids. Burns are classified according to the area and depth of injury. Superficial or 1st-degree burns involve only the outer layers of the skin, cause redness, swelling, tenderness, and usually heal well. Contact a health care professional to determine the need for treatment. Intermediate or second-degree burns form blisters, can become infected, and need medical aid. Again, contact a health care professional to determine the need for treatment.

Deep or third-degree burns involve all layers of the skin, will involve nerve damage so parts of the burned area may be pain free, may be pale and charred, and will always require medical attention.

Check:

If the burn or scald causes injury that is beyond a blister, or is over a larger area of the body;

Call:

a licensed nurse, physician or 911 immediately;

Care:

It is important not to expose a severe burn to infection or contamination.

Consequently:

1. Don't apply lotions, ointments, butter, or fat to the injury.
2. Protect the burn area from contact, if possible, while awaiting medical aid.

3. Don't try to remove any articles or jewelry or clothing..
4. Don't remove anything that is sticking to the burn.
5. Don't break blisters or otherwise interfere with the injured area.
6. Don't over-cool the consumer and cause shivering.
7. If the consumer becomes pale, begins perspiring, and is cold, ask a health care professional for instruction.

Chemical Burns

Call:

a health care professional, either a licensed nurse or a physician for instructions. Report your observations.

Sunburn

Call: Call a licensed nurse or physician if the sunburn has caused blistering or broken skin, and ask for instruction.

Care: A health care professional may advise you to:

1. Assist the victim to the shade and cool the skin by sponging gently with cold water.
2. Give sips of cold water at frequent intervals.
3. Gently apply an over-the-counter sunburn spray or cream.

+ Choking

Check:

Choking occurs when the airway is partially or totally blocked by a swallowed object (i.e., when something goes down the windpipe rather than the food passage). The aim of treatment is to clear the blocked passage. Ask, "Are you choking?" If the victim can speak, cough, or breathe, DO NOT INTERFERE. He is not choking.

THE CHOKING VICTIM WILL CLASP HIS/HER NECK IN AN INSTINCTIVE ACT, WHICH IS NOW RECOGNISED AS THE UNIVERSAL CHOKING SIGN.



Call:

If the consumer is choking, act quickly; speed is essential. Brain death can occur in 4-6 minutes. Shout for help if help is nearby. If there is anyone present who is trained/certified in first aid, request immediate assistance, and let them take over. Call 911.

Care:**Conscious Choking Adult**

1. If the consumer cannot speak, cough or breathe, give upward abdominal thrusts. To do this, stand behind victim and wrap your arms round the waist. Grasp one fist with your other hand and place thumb side of your fist in the mid-line between waist and rib cage (i.e., just below the sternum). Press fist into abdomen with 4 quick upward and inward thrusts. Keep your elbows outward to prevent rib injury.
2. Do not use abdominal thrust when dealing with a pregnant woman or overweight consumer. In these cases use chest thrusts - press on the lower third of the breastbone.
3. Repeat above sequence. Be persistent until help arrives, even if the consumer becomes unresponsive.

Self Help if you are choking

The above technique can be used successfully if a person is choking and alone. Lean over a chair or railing as you act to help release obstruction.

+ Unconscious Adult. In the event you encounter an unconscious adult consumer and the consumer's legal representative for health care decisions is not present, you must:



1. **Check:**
Check breathing, pulse and other vital signs. Use finger probe to remove dislodged foreign body in the mouth if one is visible. . Call their name and wait for a response (make sure that they are actually unconscious).
2. **Call:**
If immediately aroused, contact your immediate supervisor or licensed health care professional. If prolonged unresponsiveness (in excess of 10 minutes), or if the consumer is not breathing and/or has no pulse, call 911 (if you are employed in a facility with an on staff licensed nurse, notify immediately)..
3. **Care:**
Follow instructions of licensed health care personnel. Be prepared to provide emergency medical personnel with the consumer's advance directives, if they exist.

+ Epilepsy**Check:**

People with epilepsy can have seizures, and usually carry an identification card, or wear a medical ID bracelet. Very little first aid treatment is required, the main aims being to keep the person safe during a seizure and to provide after-care.

Call:

Report all seizures (major and minor) to the supervisor.

Major Seizure

In a major epileptic seizure, the person usually falls to the ground, loses consciousness, followed by jerking. The seizure can last five minutes or more.

Care:

1. If the person is falling, try to support or ease the fall (protecting the head) if you can do so without injuring yourself, and lay them down gently.
2. Clear a space around him so he will not be injured during the muscle contractions. If possible, loosen clothing around the neck and place something soft under the head.
3. DO NOT move or lift unless in danger.
4. DO NOT forcibly restrain.
5. DO NOT put anything in his mouth or try to open.
6. DO NOT try to wake him.
7. Position the consumer on the right side if vomiting is a potential hazard, and you can do so safely.

Minor Seizure

In a minor seizure, the person may appear to be in a daydream, stare blankly, or behave strangely.

Care:

Take care of him by protecting him from dangers such as busy roads or machinery. Remain with him until you are certain he has recovered.

✚ Eye Injuries

Foreign Body in the Eye

Check:

Particles of dust or grit or loose lashes are the most common foreign bodies found in the eye. In most cases, these are normally flushed through normal tearing... DO NOT ATTEMPT to remove a foreign body...



Call:

Seek medical aid if it is not flushed by tearing or is imbedded.

Care:

Advise the individual not to rub the eye.

Chemicals in the Eye**Call:**

Call a licensed nurse or physician and ask for instructions.

Blow to the Eye**Call:**

If there is loss of vision or visual damage, seek medical assistance.

Care:

Cover the eye with clean dressing or clean folded handkerchief and keep the consumer lying flat and quiet while waiting for help.

+ Fainting / Falling**Check:**

Fainting is a brief loss of consciousness caused by a temporary reduction in the flow of blood to the brain. Usually, the person is easily aroused.

Call:

Call and report immediately to the supervisor and ask for instruction.

Care:

1. Take vital signs.
2. If the victim is unconscious but breathing normally, lay him down
3. Loosen tight clothing at the neck, chest, and waist to assist breathing.
4. Check and care for any minor injury sustained in falling, (See bleeding).
5. Reassure the victim while regaining consciousness and gradually raise to sitting position.
6. DO NOT give anything to eat or drink until conscious, then only sips of cold water.
7. DO NOT let them have alcohol.

+ Fractures**Check:**

A fracture is a broken or cracked bone. It may be diagnosed by being felt or heard, by pain, difficulty in moving, tenderness, swelling, bruising, deformity, x-ray or symptoms of shock.

Call:

Call the supervisor and ask for instructions.

Care:

The keynote of first responder care is to prevent movement. Care for all fractures in position found. If removal to hospital is imminent, gently support the injured part by hand, place the victim in a comfortable position, and support with rolled up blankets. If there is bleeding, refer to the bleeding section.

+ Frostbite

Check:

Check for frozen body tissue, usually fingers, toes or skin. Frostbite is characterized by white, waxy skin that feels numb and hard. If you must handle the frozen part, do so very carefully to prevent permanent damage. . You can prevent frostbite by:

1. Making sure that the consumers are dressed in layers.
2. Make sure they come indoors at regular intervals to warm up.
3. Looking out for frost nip, frostbite's early warning signal.
4. Keeping an eye on the weather conditions.

Call:

It requires emergency medical attention. Call a supervisor, report your observations, and follow directions.

Care:

1. Remove wet clothing from the consumer; get them into warm dry clothes.
2. While waiting for an ambulance, give the consumer a warm drink.
3. Don't use direct heat such as electric or gas fires, heating pads or hot water bottles.
4. Don't thaw the area if it is at risk of refreezing, this can cause severe tissue damage.
5. Don't rub frost bitten skin or rub snow on it.

6. Re-warming will be accompanied by a burning sensation. There may be skin blistering and soft tissue swelling and may turn red, blue, or purple in color.
7. When skin is pink and no longer numb, the area is thawed.

Frost nip

Check:

Check fingers, toes, nose, cheeks, and ears to see if they are white and numb. Frost nip can be treated at home.

Call:

Call a supervisor, report your observations, and follow directions.

Care:

1. Bring the consumer indoors immediately.
2. Remove any wet clothing (wet clothes draw heat from the body) and bundle in clean, dry, warm clothing.

+ Head Injuries

Check:

These injuries are caused by falls, other accidents, or medical events. They can result in skull fractures, scalp wounds, concussion, brain injury/brain damage, and should always receive urgent medical attention.

Call:

Call 911 and your supervisor.

Care:

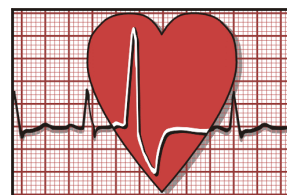
Check breathing and pulse every 2 minutes. If consumer becomes pale, cold, and sweaty, position on a flat surface.

+ Heart Attack

Chest Pain

A heart attack occurs when the muscle of the heart has an inadequate blood supply.

This may be caused by a blood clot blocking a coronary artery. This may cause the muscle to be damaged, or die, or cause interference with the electrical activity of the heart, causing it to stop beating.



When the heart stops beating, this is known as CARDIAC ARREST. Damage to the heart muscle is a HEART ATTACK.

Check:

Warning signs of Heart Attack:

- The symptoms of heart attack vary, but the most common is a prolonged oppressive pain or unusual discomfort in the center of the chest, behind the breastbone.
- The pain may radiate to the shoulder, arm, neck, or jaw (especially the left shoulder and arm). Sometimes the symptoms may subside and then return.
- There may also be sweating, weakness, nausea and shortness of breath.
- A heart attack victim may or may not become unconscious.

Call:

ALL CASES OF CHEST PAIN SHOULD BE REPORTED IMMEDIATELY TO YOUR SUPERVISOR.

Care:

1. If the victim is conscious reassure, gently support with pillows, and place in a half-sitting position with knees bent.
2. DO NOT ALLOW the victim to move unnecessarily as this will put extra strain on the heart.
3. Loosen any tight clothing around the neck, chest, and waist.
4. If the consumer becomes pale, cold, and sweaty, encourage consumer to lie down on a hard flat surface (.
5. Remove to hospital immediately, maintaining the treatment position if possible.

Unconscious Victim**Care:**

1. Put the consumer in the recovery position.
2. Check pulse rate continuously either using the radial pulse at the wrist or the carotid pulse to the side of the "Adam's apple."

✚ Heat Related Conditions**Exposure to heat and high temperatures**

The human body maintains a temperature between 96.8 F and 98.6 F. Your body regulates excess heat by sweating. Therefore you should drink plenty of water to maintain your fluid balance. Heat related conditions are brought on by exposure to high temperatures and humidity.

Check:

Check Signs and Symptoms:

- Pale, clammy skin.
- Sweating (after some form of exertion).
- Cramping pains (in the limbs and/or abdomen).
- Nausea.
- Spasms (affected limb or limbs).

Call:

Call and report your observations to your supervisor.

Care:

1. Rest the consumer in the shade.
2. Cool down the consumer with cool towel.
3. Give sips of water to drink (after nausea has passed).
4. Don't massage affected limbs.
5. Discourage any further exercise.

+ Hypothermia**Exposure to Cold****Check:**

Hypothermia is a condition that comes about when the body's heat regulating mechanism can't cope with the conditions it's working in. The metabolism gets slower, the body temperature drops, and the sufferer becomes drowsy, confused and moves unsteadily. You don't have to feel shivery in order to have hypothermia.

Call:

NEVER ASSUME THAT A HYPOTHERMIA VICTIM IS DEAD, EVEN IF BREATHING AND HEARTBEAT APPEAR ABSENT. Call your supervisor or 911, report your observations, and follow instructions.

Care:

1. Remove from cold environment.
2. If consumer is breathing but unconscious, lie flat.
3. Warm consumer gradually. Heat the room as well as the consumer.
4. Place warm material around the consumer, covering body, neck and head but not the face.



5. Conscious consumers should be given hot, sweet drinks, NOT ALCOHOL.

✚ Poisoning

Check:

A poison is any substance that causes damage if taken into the body. Poisons can be swallowed, inhaled, injected, or absorbed through the skin. Check to see if there is any obvious poison nearby.

Call:

Call your supervisor or 911 for instruction.

Care:

1. **FOR SWALLOWED POISONS:** do not attempt to induce vomiting, as this may harm the consumer further.
2. **FOR INHALED POISONS:** remove the consumer from danger and into fresh air if you can do so without putting yourself in a position of harm. Follow institutional policy if applicable.
3. **FOR ABSORBED POISONS:** flush away any residual chemical on the skin.

Care:

1. If the consumer is unconscious but breathing normally, lay her flat. If the consumer is having difficulty breathing, support her in an upright position.
2. If the consumer is conscious, ask quickly what has happened, remembering that he may lose consciousness at any moment.
3. Send any samples of vomit, pillboxes, or bottles found nearby to hospital with the consumer via the ambulance.

✚ Recover Position / Position for Vomiting

The Recover Position ensures that a consumer maintains an open airway, that the tongue cannot fall to the back of the throat, that the head and neck remain in an extended position so that the air passage is widened, and any vomit or fluid will drain freely.

IF THE VICTIM IS UNCONSCIOUS DO NOT GIVE ANYTHING BY MOUTH.

You will notice the victim is lying on his/her side, supported by one leg and one arm (Figure 1). In the case of head or ear injury, keep the injured side down.



✚ Shock

Check:

Shock is a condition of general body weakness caused by loss of circulating bodily fluids, such as loss of blood through internal or external bleeding, or loss of plasma from major burns, or through extreme pain or fear. The shocked victim may feel weak, faint, giddy, may be anxious or restless, may feel sick and may vomit. Skin may become pale, cold and clammy, sweating may develop. Breathing can be shallow and rapid, and unconsciousness may develop. Shock is present in all cases of accident to a varying degree.

Call:

Call your supervisor or 911 and follow instructions.

Care:

1. If breathing becomes difficult, if vomiting seems likely or if the consumer becomes unconscious, place in the recovery position (i.e., on his/her right side).
2. Check breathing and pulse every five minutes.
3. If the consumer is conscious, reassure and comfort him. Lie him down, raise and support legs, keep him warm and loosen tight clothing to help circulation and assist breathing.
4. DO NOT give a hot water bottle.
5. DO NOT move him unnecessarily.
6. DO NOT give anything to eat or drink.
7. DO NOT allow the consumer to smoke.

+ Sprains

Check:

This is an injury where the ligaments and tissues around a joint are wrenched or torn. It will show itself in pain, tenderness, swelling and bruising. You should document your observation.

Call:

Report a suspected sprain to your supervisor.

Care:

Rest and support the injured part in a comfortable position until given further instructions.

+ Strain

Check:

A strain occurs when muscles are over stretched or torn by violent or sudden movement. The consumer will experience sudden sharp pain at the place of injury, followed by stiffness and/or cramp. You should document your observations.

Call:

Report a suspected strain to your supervisor.

Care:

1. Place the consumer in a comfortable position.
2. Steady and support the injured part.

+ Stroke

Stroke is a Cardiovascular Accident (CVA) or disease that affects the flow of blood to the brain. Also known as a "Brain Attack".

What causes a stroke?

A stroke occurs when part of the brain is deprived of oxygen due to a blocked (blood clot) or ruptured blood vessel. When part of the brain is deprived of oxygen, nerve cells within the affected area can't function and will die within minutes. This will also affect parts of the body controlled by the oxygen deprived brain cells. So, if the brain cells can't function, then what they control won't function. Unlike other body cells that replace themselves, the effects of stroke on a person are often permanent because dead brain cells aren't replaced.

Check:

Warning Signs and Symptoms:

Remember these will occur suddenly in most cases.

- Numbness or weakness (drooping) of face, arm, or leg, especially on one side of the body.
- Confusion, trouble speaking, or understanding.
- Trouble seeing in one or both eyes.
- Unequal pupil size.
- Trouble walking, dizziness, loss of balance or coordination.
- Rapid, full pulse.
- Severe headache.
- Collapse.
- Convulsions.
- Coma.

Call:

If you observe any of these signs and symptoms, report them immediately to the supervisor and await instructions. If the supervisor is not available, call 911.

Care:

1. If conscious, reassure and make the consumer comfortable.
2. Keep the consumer calm.

3. Maintain eye contact. Speak slowly and clearly.
4. Give nothing by mouth.
5. If unconscious and breathing, lie the victim down.

Transient Ischemic Attack (TIA):

This is a "Little Stroke or Mini Stroke." Victim may show any of the above stroke signs. These may only be temporary and last a few minutes or hours. About 10% of strokes are preceded by TIAs.

7

Module 7: Introduction to Job Skills



OBJECTIVES

After completing this module, you will be able to do the following:

Entering the Human Service Field

- List potential barriers that may be part of a consumer's environment and circumstances.

Basic Work Skills and Job Maintenance

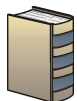
- Define the responsibilities of the Personal Support Specialist;
- Define the personal characteristics required to be a Personal Support Specialist; and
- Define the requirements for the Personal Support Specialist with regard to health, hygiene and appearance.

Ethical Aspects of Care

- Define the meaning of rights of residents in DHS licensed facilities in the following areas: services, finances, residential facility, grievance, privacy, freedom from abuse, choice;
- Define the rights of consumers in different settings;
- Define the legal responsibilities and protections of the PSS with regard to reporting incidences of rights violation, suspected abuse, neglect or exploitation;
- Define the meaning of ethical behavior for the PSS; and
- List 3 ways to promote consumer independence and self-advocacy.

Improving Communication

- List the 5 steps of listening and responding in the Roger's communication method;
- Define 10 principles for improving communication;
- Define the 6 steps in the problem solving process;
- Describe 2 types of specialized reporting forms;
- List 4 types of information that should be recorded in daily progress notes;
- Identify 2 types of unusual situations that must be recorded in incident reports;
- Demonstrate the ability to record observed behavior correctly in an objective manner; and
- Demonstrate familiarity with common reporting forms.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Work management skills
- Observational skills
- Judgment
- Interpersonal skills
- Self management
- Care or service plan
- Self advocacy
- Empathy
- Conflict resolution
- Progress notes
- Flow sheet
- Incident

ENTERING THE HUMAN SERVICE FIELD

Seeing the Consumer's Potential

The PSS may be asked to support people by helping to eliminate barriers that stand in the way of the consumer being as independent as he/she can be and having a meaningful life. Some barriers may be within the consumers themselves. The consumer may let the PSS do things for them when they usually do these things alone. Some barriers may be part of their environment and their circumstances. What can you think of that may be a barrier and how could it be reduced or eliminated? Who is responsible for identifying, reducing or eliminating barriers?

➤ Debunking “dependence”

- Do you ever see consumers who you feel could be doing more for themselves? For example, if a consumer performs an activity independently but with difficulty because the cleaning supplies are on a back shelf under the counter, what might you suggest be removed as a barrier?
- Have we, the consumers' families or the “system” made them dependent? Is it sometimes faster for the PSS to make the bed rather than have the consumer help with the task?
- Do you work with consumers who think that they can't learn how to do something or that they can't relearn how to do something that they've forgotten? Try breaking the task down into small, simple steps with short, clear instructions. *Note: See Module on Teaching Skills*

➤ Choice

- Individuals need to decide what they want to learn, to do, or to be. Choice can be as simple as the color of the clothes or the way food is prepared.
- Consumers may not always make the same choices we would make but it won't work to force our choices on the consumer.
- Can you remember a time when someone told you what you had to do and it wasn't what you wanted to do? Imagine being told at the age of 83 you had to go back to your room because it is not time for supper. For many consumers, sitting around the kitchen table was a place of socialization.

- Normal Social Role
 - Consumers generally have lost much in their lives by the time they begin to receive our services. Nothing feels very “normal” any more.
 - What can you do to try to help consumers regain a sense of “normal” in their lives? How do you know what is “normal” for the consumer?
 - What are the things or events in the environment that don’t seem very normal?
- Each person is an individual
 - Every consumer has different strengths, abilities, and needs from every other consumer. Even people with similar appearance, age, and/or diagnoses are significantly different from each other.
 - What does your employer do to emphasize those differences?
 - What happens to blur those differences?
- Commitment of staff
 - Your role as a PSS is critical to the independence and well-being of the consumers you work with. They depend on you and look to you for support.
 - How do PSS staff demonstrate their commitment to the consumers?
- Do you need to be a professional?
 - This is a way of saying that you don’t need a specialized degree in order to see the consumer’s potential. Anyone (including doctors, nurses, social worker, PSS’s, housekeepers, etc.) can support consumers with these principles.
 - What are some examples of times when it didn’t matter what the job title was in order to support a consumer well?
- Change the environment
 - As we’ve already talked about, sometimes the barriers to a consumer’s success are not inside the person but, rather, are in the environment. As much as it is in our power, we would be looking for ways to reduce the environmental barriers to independence.
 - What are some physical barriers?
 - What are some social barriers?
 - How have barriers been eliminated in the past?
- Goal-directed activities
 - For people who are able and willing to work, work is a wonderful way to gain some independence and may also support an enhanced social life. Not everyone is able or willing to work in a traditional job. Maybe it’s easier to think about work being what goal-directed activities people choose to do to occupy their days.
- Social rather than medical focus

- Each of us has health related issues but most of us would not define ourselves by our health problems. WE would be more likely to define who we are by what we've accomplished, our families, our work, our hobbies. The same should be true for the consumer. It's important to understand the health and medical issues of consumers, but psychosocial information – learning more about the “person” - is extremely important when helping to bring out the potential of the consumer. For example, can you describe a consumer without first mentioning his/her disability or illness?

BASIC WORK SKILLS AND JOB MAINTENANCE

The Personal Support Specialist Responsibilities

When you look at the various roles or jobs, you will realize that you are part of a team. The team's overall job is to provide personal supports to consumers. Although members of the team do different tasks (chores), the team members have certain responsibilities and rights in common.

You should be fully informed about your responsibilities as Personal Support Specialist. You must take time to become familiar with these responsibilities in order to accurately follow the regulations that apply to your job. As this course will stress repeatedly, your employer participates in a heavily regulated industry. In this position, you will be entering into a legal relationship with the consumer and your employer. Your responsibilities do not go away simply because you did not take the time to learn them. As the old saying goes: "Ignorance of the law is no excuse." Similarly, your rights cannot be protected unless you learn about and know what they are.

If you are to be effective, you will become familiar with any state or federal rules that apply to your employer. If you change employers learn what new or different rules apply to them. Knowing the law means you will not accidentally violate regulations, and will not tolerate such violations by others. *Become familiar with the regulations.*



The Personal Support Specialist performs a major role in home care, residential care, and adult day care.

Personal Support Specialists assist consumers with *instrumental activities of daily living* (IADL) and *activities of daily living* (ADL). You will need to

learn about consumers' rights and needs and what you must do to provide for them.

Job Responsibilities of the Personal Support Specialist

The Personal Support Specialist usually works as part of a team, under supervision. Your employer (in a detailed **job description**) and your supervisor will tell you specifically which activities you will perform. You should also ask your supervisor or employer for a copy of your job description.

NEVER perform any activity that is not specifically part of your training and job description even if you think you understand how to do it, or are requested to do it by anyone, including your supervisor. Your employer may train you to perform additional duties that are not covered in this training but may be included in your job description.

NEVER try any activity you do not understand. Ask your supervisor to explain it so you understand it.

The 2 statements above are essential for all health care. These are what we call foundation concepts.

Personal characteristics required to be a Personal Support Specialist.

You will be working with people, providing a personal service. The standards for this are as high as the standards by which you treat yourself and by which you like to be treated. Consider, too, that the people you serve have had their lives affected by age, illness, or disability. You must pay special attention to how you treat them. Your attitude, behavior, and appearance are all a part of that. Attitude matters. Your attitude will affect the consumers and other members of the team with whom you will work. If you consider how much more you enjoy being with people who are enthusiastic, friendly, and cheerful, you can see how much more effective you will be if you have a good attitude.

Ethical behavior is necessary. Ethics are standards of conduct based on morals. Consider these to be personal requirements for the job. No employer may force you to perform an illegal or unethical act. The requirements of ethical behavior are discussed in detail later in this training.

You must have good personal hygiene. You will work closely with consumers. Bad breath or body odor (including strong deodorants or perfumes) will hurt your ability to perform your duties. An unclean body

or clothes will also offend consumers and may violate requirements for infection-free care. The Personal Support Specialist needs to:

1. Bathe or shower daily;
2. Wash hands frequently;
3. Keep teeth clean and breath fresh; and
4. Have no noticeable body odor or fragrances.

You must present a neat, clean and orderly appearance. The Personal Support Specialist needs to:

1. Wear required clothing and identification;
2. Wear clothes that fit comfortably and neatly to allow the freedom of movement necessary to perform your duties;
3. Wear shoes that fit correctly, are closed-toed, supportive, and comfortable;
4. Keep clothing clean;
5. Keep hair clean, neat, and off the shoulder/pulled back if long;
6. Fingernails should be neat and trim;
7. Avoid wearing jewelry that can scratch or be pulled. No dangling earrings or large hoops; and
8. Avoid wearing heavy make-up, perfume or hairspray.

Your employer will have specific requirements for your health, hygiene and appearance. Learn these requirements and practice habits that help you to meet them on a regular basis.

Other skills and characteristics required of the Personal Support Specialist include **work management skills, observational skills, judgment, interpersonal skills** and **self-management**.

WORK MANAGEMENT SKILLS (collaboration, organization and role clarity):

Collaboration

The PSS

- Establishes and maintains effective working relationships with all levels of personnel.
- Understands and appreciates the different views, expertise, and experience of others; understands the perspectives and limitations of other individuals and systems.
- Identifies and understands what resources are available and seeks guidance when needed.
- Uses own support network (including supervisor) appropriately to get feedback and process issues.

Organization

The PSS

- Plans work activities to ensure services are provided at the appropriate times.
- Gathers supplies and materials needed to provide services in a productive and timely manner.
- Maintains personal work area in a neat and orderly fashion.

Role Clarity

The PSS

- Understands roles and responsibilities of staff
- Clarifies responsibilities and boundaries of the PSS role

OBSERVATIONAL SKILLS:

The PSS

- Recognizes inconsistencies in information or observed behavior (“What’s wrong with this picture?”)
- Describes factually what is observed without using language that presumes values and motives.
- Identifies behavior that is out of character or atypical.
- Identifies trends or patterns in behavior over time.

JUDGEMENT:

The PSS

- Thinks through the implications of situations or events to predict consequences.
- Recognizes when a situation requires emergency response.
- Maintains perspective on what is urgent and what can wait, what is important and what is not.
- Recognizes personal knowledge limitations and when to seek advice or assistance.

INTERPERSONAL SKILLS (sensitivity, communication skills and diversity):

Sensitivity

The PSS

- Is sensitive to consumers’ moods.
- Is sensitive and takes steps to interpret non-verbal cues as to what consumers are thinking and feeling.
- Discovers and respects the preferences and unique aspects of each consumer’s personality.
- Can view situations from others’ perspectives and empathize with their feelings.



Communication Skills

The PSS

- Listens to consumers; lets them know they have been heard and their feelings considered.
- Tailors communications to the consumer's level of understanding (without talking down to the consumer).
- Maintains a non-judgmental and open attitude when communicating with consumers, service providers, and facility staff.
- Uses a variety of questioning techniques to elicit information needed to make decisions.
- Prepares clear, accurate, factual, and appropriate documentation.

Diversity

The PSS

- Demonstrates respect for consumers regardless of differences.
- Acts in compliance with relevant law and policy (Civil Rights, ADA).
- Understands and is sensitive to differences in culture, ethnic and religious values, gender, sexual orientation, perceptions, customs and behaviors.

SELF MANAGEMENT (job commitment, flexibility, self-control and responsibility, self-development and stress management):

Job Commitment

The PSS

- Sets and models high standards of personal conduct.
- Gives consumers extra attention when needed and is patient when interacting with consumers.
- Committed to the welfare of consumers.
- Models a professional and positive attitude.
- Genuinely likes consumers and is enthusiastic and energetic when interacting with them.
- Can admit and own mistakes and then be proactive in solving them.

Flexibility

The PSS

- Is not thrown off balance by a need to change plans at the last minute.
- Is able to juggle attention to people and tasks effectively.
- Adjusts to working with a variety of professionals.
- Accepts change in policies and procedures affecting their work environment.

Self-Control and Responsibility

The PSS

- Demonstrates accountability for actions.
- Can admit own mistakes and be proactive in solving them.
- Responds to emergency situations in a calm and professional manner.
- Restrains impulses to respond immediately and takes appropriate safety precautions in situations that may place self in personal danger.

Self-Development

The PSS

- Takes advantage of training and other learning opportunities.
- Actively solicits feedback, recognizes needed changes, and integrates them into performance.

Stress Management

The PSS

- Understands and is able to identify the causes and effects of stress and techniques for effective stress management and self-care.
- Knows when to take time out, to step back from a situation, to calm down, to think things through.



Health, Hygiene and Appearance

Note: Refer to the text “Personal Care in the Home” pages 8 and 9.

ETHICAL ASPECTS OF CARE

Consumer Rights

When people move into residential facilities, they do not lose the rights they had at home that are protected for all of us by the US Constitution, the Bill of Rights, and other federal/state laws. Living in a residential facility does not automatically change an individual's legal status. In the role of PSS, it is important to remember that the people who you are supporting in the facility should be viewed as whole people who have the same rights that any other citizen has.

Whenever someone gives up some control over his/her life in order to get help or support, he/she becomes more vulnerable. The person may feel that the staff or his family have all the power and that he must do what he is told to do. The State of Maine, acting on behalf of all of us, has specified rights that must be preserved when someone enters residential care. The Department of Human Services regulates the rights for people living in facilities.

Several state agencies are involved in protecting the rights of consumers. You should become familiar with these agencies. The state must be notified of any consumer rights violation as well as when abuse or exploitation is suspected. Such reporting is confidential and state law protects those who report from legal reprisal if they report in good faith. You are protected under the Maine Whistleblower's Act. There should be Whistleblower information posted at your place of employment.

- **Adult Protective Services**, in the Bureau of Elder and Adult Services, provides a number of services designed to protect all adults from abuse, endangerment and exploitation. They investigate complaints of abuse, neglect and exploitation and may take punitive actions if indicated.
- **The Disability Rights Center** is Maine's protection and advocacy agency for people with disabilities. It is a state and federally supported freestanding non-profit agency that investigates and may bring legal actions in support of persons who have had their rights violated. The Center provides information about rights and service systems, referrals to appropriate individuals and groups, and training on rights and advocacy skills.
- **The Maine Long-term Care Ombudsman's Office** is an advocacy program established by the Older Americans Act of 1965. The Ombudsman volunteer project sends volunteer visitors into facilities on a regular basis to talk with consumers, to solve complaints, or to refer complaints to other authorities.
- **The Office of Advocacy** of Behavioral and Developmental Services has responsibility for investigating and acting upon service access problems for persons with a mental illness or mental retardation.

- **Behavioral and Developmental Services (BDS)**
- **Department of Human Services (DHS)**

Some consumers may be served concurrently by both DHS and BDS.

Legal Considerations

All health care and long term care programs have a set of guidelines for what is considered good care. Following the standards of care also protects you, the caregiver. As a PSS you are liable, or legally responsible, for your own actions. An important legal concept that applies to your position is negligence, an unintentional wrong that causes harm to a consumer. (A similar law, malpractice, is negligence committed by a professional, such as a physician, nurse, or pharmacist.) Negligence can be either performing an act without reasonable care or failing to perform an act that should have been performed. These are called acts of commission and omission.



For example, as a PSS, you are negligent if you cause a consumer harm by:

- Disregarding a supervisor's instructions or performing a task that is not part of the service plan;
- Performing a task incorrectly or unsafely;
- Performing a task without proper training;
- Performing a task that is not in your job description, even if you are told to do it by a nurse or other professional.

Note: Refer to the text "Personal Care in the Home" page 16 for further discussion of legal issues.

Ethical Considerations

Ethical behavior means doing what is right and meeting your responsibilities.

Ethical behavior for a PSS includes:

- Performing your duties to the best of your ability;
- Being loyal to your employer and coworkers;
- Being honest, truthful, and accountable. It is never appropriate to accept anything of value from a consumer. If the consumer insists on

giving you a gift, consult with your supervisor about what is appropriate;

- Carrying out your supervisor's instructions. Asking questions if you believe what you are being asked to do is wrong (illegal or unethical);
- Performing only those duties within your job description;
- Giving respect to all consumers, regardless of their beliefs, background, or opinions;
- Keeping consumers' personal information confidential;
- Providing privacy during procedures;
- Providing care that is free from abuse, mistreatment, or neglect;
- Safeguarding consumers' property from damage, loss, and theft;
- Reporting accidents or errors to your supervisor immediately.

Service Planning

Before we decide what services a consumer will receive, a consumer will be assessed to determine what their needs are.

A **care or service plan** is the written document that captures the data developed in the assessment and next converts it to specific, planned, scheduled activity. It must be structured in some logical form that allows a reviewer or staff member to quickly follow the stated process from goal or need statements to current status. Service plans are regularly reviewed by state inspectors.

This plan, then, is the blueprint for carrying out all those actions that will result in a range of services needed by each individual consumer. The consumer has control of this process, and may bring into it those family members, friends or staff he or she wishes to include. Progress notes that comment on the steps in the plan being implemented must be entered and kept.

Promoting Consumer Independence and Self-Advocacy

Encouraging Independence

Throughout this training, we have talked about your role in supporting the people with whom you work. Your job is not to “take care” of people; “taking care” of people increases their dependence on you. Your job is to encourage people to be independent in as many ways as they can for as long as they can. For some, this will be the first time in their lives that they have the opportunity to act independently. They may have lived in very protective families or

institutions. Others may have lived most of their lives independently. They may be feeling a loss of independence by being in a facility or by receiving home care. Still others may view their current situation as a time to be waited on by staff. Each of these situations requires you to actively promote opportunities for people to do as much for themselves as they can.

Self-advocacy

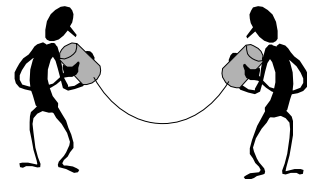
An advocate is someone who acts on behalf of someone else. When you tell your supervisor that a consumer is being taken advantage of by their family member, you are advocating for the consumer's rights. When you tell a waitress that your companion is perfectly capable of ordering his own food, you are advocating for his dignity. **Self-advocacy** is encouraging consumers to speak up on their own behalf. It may mean giving a consumer a non-verbal communication that it is okay to tell the waitress that your companion can order for himself.

You should always see yourself as an advocate. If you are always the one doing the advocacy however, it doesn't support the consumer to become more independent and to take responsibility for self-advocacy.

IMPROVING COMMUNICATION

Communication

Communication is the exchange of information between people. You are constantly communicating even when you are not speaking or writing. Your job requires you to communicate regularly with consumers and co-workers. You must be clear, accurate, and understandable. The health and welfare of consumers depends on it.



Empathy, your ability to understand things from another person's view, is necessary for good communication. Careful listening and observation are required. This is especially true wherever there are cultural, physical, religious, or other basic differences between people.

Knowing your role and its requirements is also necessary for good communication. This provides you with the basis to understand others and to make yourself understood. You have not communicated unless you have been understood. Developing good communication skills takes effort and practice. It

will increase your effectiveness and success and will keep you from communicating the wrong information.

Your employer will have specific requirements for reporting consumer information and for other communications with consumers and co-workers. You are expected to follow such requirements.

There is a model of communication, which is widely used in care environments. Attributed to psychologist Carl Rogers, the model aims to increase comfort, accuracy, openness and efficiency in staff-consumer interactions. It responds to the need each of us has to be heard, understood accurately, and valued. The Rogers method is really a model of listening and responding, and is particularly effective in:

1. Establishing and building connectedness;
2. Confirming that ideas and emotions have been accurately heard and validated;
3. Generating communication that helps identify possible solutions and actions;
4. Confirming what information has been heard and what its meaning is; and
5. Reviewing what follow-up behavior will occur and what specific actions will be taken.

This model consists of five steps carried out by the staff member. The five steps in the model are described below:

1. **Attending:** Indicating to the consumer that s/he has your attention, and that you are interested in getting on his/her "wavelength." "Hello, how are you?" is an attending behavior. "You look a little down today, Bob, and I wondered if you were upset" is an attending behavior. The purpose here is connecting with the person.
2. **Reflecting:** Repeating-back to the consumer what you have heard him say and how he seems to feel about it at the moment. This step confirms that the consumer is being listened to, heard accurately, and that his feelings and issues are both being heard, without being judged. "What I'm getting from you, Bob, is that someone has messed up your room, and that you're very upset," is a reflective response. This is also a self-correcting process. If we've got it wrong, the consumer can immediately clarify what he is saying and how he feels.
3. **Communicating:** After a period of reflecting, conversation begins to flow. At this point, the real give-and-take of communication occurs, with problems being discussed and solutions identified. This stage may last from just minutes to an hour. Here the staff member acts as a sounding board, helping the consumer get his/her concerns out, testing ideas, thinking it through, and assisting the consumer to come up with useful ideas. It is not a period of advice giving. In this stage

both parties offer ideas and observations and respond to each other in a balanced way as they would in any useful conversation.

4. **Summarizing:** When adequate communication has occurred so that the consumer has had an opportunity to fully express himself, the staff member takes on the task of carefully summarizing the important ideas of the conversation, and how the consumer has felt about them. For example: "OK, we've discussed your problem with your roommate, Bill, and his taking your stuff. I know that has been hard for you, and you want something done about it quickly. You're fed up with his taking your things," is a summarizing comment.
5. **Initiating:** After summarizing what has been discussed, the staff member now states what is to happen, when it is to happen, and who will do what. The purpose here is to make clear what kind of follow-up will occur so that both consumer and staff member are in agreement. If there are disagreements now, they can be compensated for and disappointment will not result. It's important that conversations like this result in some concrete action that addresses consumer needs. "Well, Bill, I'm going to speak with the consumer care director on your behalf right after lunch. I'll explain that you're having trouble with your roommate, and see what she says. I'll get back to you before dinnertime. I'm sure we can do something about this." is an initiating comment.

Use of the following principles will assist you in being a better communicator and therefore a more effective PSS:

- **Reflect**, rather than merely asking questions. The person will feel heard and not "interrogated."
- **Use** open-ended questions that encourage a thoughtful response rather than simple "yes/no" questions.
- **Attend** and observe the consumer's emotional state.
- **Listen intently** to the consumer, offering frequent confirmation by reflecting, while limiting your own comments.
- **Help** the consumer to *think through* implications of the situation or problem, and avoid offering advice.
- **Summarize** communication, so the interview concludes with everyone feeling sure about what has been discussed.
- **Initiate**, so everyone is clear as to what will happen next and who is supposed to act.
- **Go slow** in finding solutions. Never push a consumer toward a solution.
- **Follow up** after the conversation is concluded. Let the consumer see that you're actually helping.
- **Understand** your own control and dominance needs and keep them in check. Moderate your own impulse to control, and instead really *listen* to the consumer.

Problem Solving

Problem solving is another communication technique that you will use. Consumers and coworkers will frequently approach you with issues, concerns, or problems. You may have to assist them in finding solutions. The problem solving method produces an organized way to determine possible successful solutions to problems. The six steps involved in this process are:

1. Determine the problem: be sure you are very clear about what the problem really is. Use active listening skill and clarification to be sure you understand what the person believes the problem to be.
2. Develop solutions: with the person or persons involved, write down all possible solutions to the problem. Use all you can think of. Sometimes a solution may appear not to be workable at first, but actually is a good idea when you look at it again.
3. List the positives and negatives about each solution.
4. Determine which solution will be tried first.
5. Implement the solution.
6. Evaluate your results.

Conflict Resolution

Wherever you have groups of people working or living together, conflict or disagreement is bound to occur. Squabbles over who is first on line or who said what to whom are typical. To work successfully in the health care environment, you will need to develop conflict resolution skills. You may be called upon to manage and resolve conflicts between consumers and you must be ready to manage communication in such difficult moments. In the future if you become a supervisor, you may also be required to assist in the resolution of conflicts between staff members or staff member and consumer. You may be involved in conflict with your consumer. **Conflict resolution** is solving a disagreement. Proper management of conflict involves creating a win-win situation where both parties feel heard, valued and respected. You would use the following steps to hopefully reach a positive outcome:

1. Listen to each other;
2. Engage in fact-finding – both need to identify the issue; and
3. Negotiate a solution which may involve compromise by both parties.

Examples and Approach

Staff frequently become involved in psychosocial relationships between the consumer and others when disputes or conflicts occur. Conflicts between house or roommates are common in all settings.

Conflict may arise over matters such as:

1. Planning activities
2. Possessions
3. Friendships
4. Dining room seating
5. Menus
6. Room assignments
7. Rules of the home
8. Clothing for the day

Mrs. Smith and Mrs. Jones may be arguing over who will “call” bingo. Mrs. Benson told the administrator that Mrs. Sexton stole her comb. Jack and Pete are mad because each thinks it is his turn. Elvis wants to listen to music in the dining room while Sam wants to watch TV - now they are shouting. Some conflicts require a very long time to resolve; other conflicts may be resolved in minutes. Basic conflict resolution techniques accompanied by problem solving can solve most of these issues.

As a staff member, you should know how to use the Conflict Resolution process. The Conflict Resolution technique produces certain benefits for all involved. It allows each person to realize that he/she is heard and understood. It validates their feelings and builds self-esteem. It also focuses on a “win-win” situation or compromise. Here each person comes away believing that he or she was not a loser in the situation. These are very positive effects.

Conflict Resolution Technique

The technique itself consists of the 5 steps outlined below:

1. Separate the people in conflict as long as you can do so safely. Take them to a neutral place while explaining that you are going to be discussing the problem. Once in a neutral place, everyone should sit down.
2. Encourage people to use “I” messages.
3. Hear both sides of the argument. Make sure each person is permitted to fully explain his/her opinion, but be sure to stay focused on the issue. Have each individual express their opinion and feelings about the problem. Everyone else listens. When someone interrupts, remind him or her it is not his or her turn. Avoid any disrespectful body language. Make sure the person speaking stays on the topic and does not wander off into other subject matter.
4. Once each person has had the chance to express himself or herself fully, you should summarize what he/she says and ask the speaker if he/she was understood correctly.
5. Now, you will begin to use problem solving to come to a solution, and work with both parties to come up with ideas for solving the problem.
 - i. As a group, define what the problem is.

- ii. Develop solutions for the problem.
- iii. Look at the positive and negative aspects of the solutions.
- iv. Get agreement from both parties on which solution will be attempted.
- v. Summarize problem and solution. Be sure everyone knows what their job is in relation to the solution.
- vi. Decide when to return to evaluate results if needed.

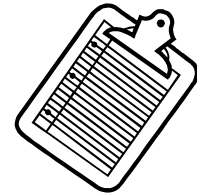
After the solution is implemented, check back to see if it is working; if it is not, begin the process again.

Documentation

The amount and type of documentation varies depending upon the program in which you are working. The type of documentation that you will be required to complete will be provided to you during your orientation.

Note: Refer to the text “Personal Care in the Home” pages 22-25.

The following two types of special reporting are designed to capture exactly what happened, with related details, rather than relying on memory or brief notes. Later, these details may be needed should complications arise.



1. **Progress notes** are the “log” of events and situations. Some employers call them visit reports, activity sheets, progress notes, communication logs and report books. Check with your employer to find out what will be required in your setting. They become part of the consumer’s record. This documentation could contain information about moment-to-moment activity in which one, several or all consumers may be involved. This documentation should describe your first hand observations concerning:
 - **consumer activities** such as bathing, bed rest, sleep, eating, elimination, ambulation, and movement. Be sure to note whether the consumer performed these activities without assistance (self) or with assistance (assisted).
 - **Consumer statements** about pain or discomfort, appetite and diet, etc. should be included. Be sure to note that these were said by the consumer.
 - **Physical conditions** such as obvious signs of pain, swelling, skin discoloration, skin irritation, body odors, breathing difficulty, gas, coughing, vomiting, and diarrhea must be noted.

- You must also record **mental conditions** such as awareness, confusion, forgetfulness, hyperactivity, and consciousness.

Your employer will give you specific documentation required for each consumer.

2. **Flow sheets** document the tasks and procedures the PSS performed for the consumer. Flow sheets are usually in the form of a check-list supplied by the employer.

Incident reports are required in the event of unusual situations. An **incident** is defined as something that is “unusual” for the person or situation. Unusual situations include:

Emergency Medical Incidents:

- Falls,
- loss of consciousness,
- any rapid changes in consumer condition,

Other Non-Medical Incidents:

- missing articles of clothing or possessions,
- consumer-to-consumer altercations,
- falls or accidents with visitors or staff, and
- missing consumers/elopements.

How To Handle Errors in Documentation

Late Entries: Late entries are entries added on another day or another shift other than the one on which it happened. The proper procedure for correction of late entries is to write “late entry”, date the entry with the date that you are writing it, with a reference to the date it occurred.

Effective Written Communication: Basic Considerations

Written communication is an important form of information sharing in most care systems. Traditionally, written communication has been a neglected art in social service arenas. There is often a need for the PSS to bring more effective written communication to bear on the care process. We can each improve our written communication through routine attention to a few basic considerations.

1. Conveying Information through Written Communication
 - A. Achieving Clarity
 - i. Writing works only if it is targeted to getting across well-defined information in as clear a manner as possible. This means focus, simplicity and careful editing.

- ii. When writing, select your subject, present information that bears on that subject only, use short, simple sentences, target your prose and edit for clarity.
- iii. Can the reader make sense of what you've written? Could you act based on the information you've written? Have you avoided jargon? Have you written in simple sentences, using a subject, verb and object? Achieving completeness have you included all the information necessary to relate a complete idea?

B. Legibility, Grammar, Syntax

- i. However well written, a document is of little use if it is so illegible it can't be read or relied upon. Similarly, a professional document should contain no errors of syntax, punctuation problems or misspellings.
- ii. Many staff documents (assessments, progress notes, disciplinary records, et cetera) are frequently used in administrative or court proceedings, where they may be presented as evidence. Thus, even an informal memo or report may have legal weight in the future. It is vital that all written documentation be legible, reliable and credible.
- iii. Regular use of a dictionary, basic grammar guide and a thesaurus can assist in avoiding writing errors.

C. Familiarity with and Correct Use of Standard Forms

Every PSS should be familiar with the standard forms used. Being familiar with their use and application can make your written communication more effective.

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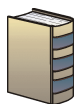
Module 8: Understanding the Consumer as an Individual



OBJECTIVES

After completing this module, you will be able to do the following:

- List the 5 basic human needs in Maslow's hierarchy of needs;
- Describe the role of the PSS with regard to consumers with disabilities;
- Describe the role of the PSS with regard to the consumer's family, customs and values;
- Demonstrate the ability to understand consumer behavior;
- Demonstrate the ability to respond appropriately to annoying behavior;
- Demonstrate the ability to respond appropriately to aggressive behavior;
- Demonstrate the ability to use the Brief Counseling technique; and
- Describe the role of the PSS with regard to human relationships and sexual behavior as it relates to consumer care.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Illness
- Disability
- Cognitive impairment
- Behavior
- Conflict
- Annoying behaviors
- Aggressive behaviors
- Brief Counseling Technique

Basic Human Needs

The consumer is a person, not an illness or condition. Honoring each person as an individual is a fundamental principle of home care and residential care and meets a basic human need.

All people have the same kinds of basic needs. A useful way to look at this is the hierarchy (a system of things in ranked order). The psychologist Abraham Maslow designed the following hierarchy of basic needs:

1. Physiological (the lowest level); eating, drinking, elimination, sexual contact, shelter, etc.
2. Safety: security for person and property (including money)
3. Love and belongingness: Support and affection from relationships and roles with family, friends, and society.
4. Esteem: the respect, regard, or value of others and yourself.
5. Self-actualization (the highest level): achieving what you are capable of achieving.

People generally have to satisfy one level of need before they can satisfy the next level. The goal is self-fulfillment. Failure to satisfy needs will cause frustration, anger, helplessness, depression, etc. Personal growth is not a linear process. During the course of one's life people normally go back and forth on this pyramid.

The PSS helps consumers satisfy as many of their needs as possible. A fundamental step in this process is assisting the consumer to provide as much self-care as possible for the activities of daily living such as eating, bathing, dressing, etc. In general, the more self-care consumers can provide, the greater their sense of independence and self-esteem.

Illness and Disability

Definitions:

- Depression: sadness, discouragement, gloominess
- Cognition: ability to think, know, or understand
- Impairment: a reduction
- Prosthesis: an artificial body part

The PSS must accept and respect the consumer's feelings and be sensitive to the needs of such consumers. Illnesses and disabilities can make satisfying the most basic needs more difficult. An **illness** is a loss of health. A **disability** is a loss of function. Serious illnesses, mental disorders, and physical disabilities

require special care and consideration. In such cases, the home care agency and residential care facility must provide for both the consumer's basic needs and special needs.

Illness and physical disability always have a serious psychological impact. It is normal for an illness or physical disability to cause feelings of dependence and inadequacy, which in turn can lead to depression, frustration, or resentment. Some consumers may express these feelings to you directly or they may do so indirectly by not cooperating in their care.

Physical Disability

Physical disabilities such as paralysis, loss of limbs, and eyesight and hearing disorders may cause powerful feelings of frustration and helplessness. With the right assistive devices, prostheses (artificial body parts), teaching and assistance, consumers with disabilities may be able to perform self-care that would otherwise be impossible. This will increase their independence, improve their quality of life, and help them to feel good about themselves.



The goal of the PSS is to help consumers with disabilities achieve as much self-care as possible. Hearing aids, special eating utensils, walkers, wheelchairs, and prostheses are among the items that are used by clients to provide self-care. When working with consumers with physical disabilities, the PSS should be:

- sensitive to the consumers' feelings
- respectful of their mental and physical abilities
- familiar with the assistive items they use
- encouraging and positive about their efforts at self-care

Cognitive Impairment

The brains of cognitively impaired people do not allow them to understand, remember, or think in normal ways. People can be born cognitively impaired or can develop it in later life from physiological causes. Mental retardation and autism are types of cognitive impairment people have at birth. Strokes, brain injuries, Alzheimer's disease and medication are among the physiological causes of cognitive impairment developed after birth.

Physiologically caused cognitive impairment that gets progressively worse is called dementia. Alzheimer's disease is the most common cause of dementia. An early symptom is forgetfulness, which progresses to complete loss of emotional and intellectual control and then death. These consumers often become more confused or agitated late in the day, a condition known as "sundowning".

Communication with the cognitively impaired is difficult, so special training should be obtained before working with persons with cognitive disabilities.

Family, Customs, Values

Note: Refer to the text “Personal Care in the Home” pages 32-33.

The consumer’s home is a place of family, customs, and values. In addition to health, each person’s life is built upon family relationships, religious beliefs, and cultural heritage. In every case, these aspects of their lives will influence their care. The family is very important in both home and residential care settings. Whether the family members are living in the home with the consumer or elsewhere, they play an important part in satisfying the consumer’s needs and in the success of the consumer’s care.

Family

Family relationships are often the most meaningful parts of a person’s life. They can be a source of pleasure and strength, but also of pain and stress. Whatever the nature of the relationship, the consumer’s feelings about it are often intense.

The relationships of consumers and their families are complex. The family may be psychological or financially dependent upon the consumer, or the reverse may be true. The family may or may not be supportive of the consumer. There may be many conflicts between family members.

The consumer’s family frequently plays a major role in the consumer’s care by creating a positive or negative environment for care. When appropriate, you should explain to family members how they can support the consumer’s care. It is important to remember that, although you have entered the consumer’s home, you are not a member of the consumer’s family. It is important to maintain professional boundaries. For example, do not participate in family disputes. If you believe you see any problems with the consumer’s care because of family reasons, you should report them to your supervisor.

Religion and Culture

Religion and culture are important considerations for almost every consumer. They provide a sense of security, purpose, and meaning. They also create habits and ways of looking at life that become a basic part of the consumer’s identity. They often lead to strong beliefs about:

- diet
- clothing
- personal hygiene
- sex
- health care

- illness
- death

The PSS must accept and respect the consumer's beliefs and practices. They must also help consumers find satisfaction in these areas (for example, following consumers' dietary preferences when shopping for and preparing food).

If you believe a consumer's religious or cultural practices are hurting his or her care do not debate with the consumer - report it to your supervisor. Any disrespect of a consumer's religious and cultural beliefs or practices is a severe personal insult.

Principles of Human Behavior

All human beings display behavior. **Behavior** consists of nothing more than actions displayed in response to stimuli. For example, you give a consumer a cup of coffee. The consumer drinks it. Your behavior was going and getting the coffee. In response to your offer, the consumer displayed the behavior of the drinking the coffee. We see behavior everyday - at home and at work. Most of the time, the behavior is predictable and considered "appropriate" for the situation, so our expectations are satisfied.

The PSS needs to identify and understand consumer behavior and respond appropriately. Behavior is both purposeful and learned. A person does something in order to satisfy a need or desire. If that need or desire is satisfied, the person is more likely to repeat the behavior the next time the situation arises. Behavior is not considered positive or negative- it just "is" or exists. A consumer may throw himself on the floor when he sees McDonald's. He has learned that this behavior will cause his family to buy him a "shake" which satisfies his hunger needs. For this consumer, "throwing yourself on the floor" is an effective behavior because it satisfies a need. In the field it is important for staff to avoid labeling behavior as "difficult", "bad", or "negative". The challenge for staff is to support the consumer in getting her needs met in ways that do not prevent other people from meeting their own needs.

Whatever behavior a consumer exhibits, the PSS must respond appropriately. Some behavior may stimulate unpleasant feelings and emotions in you. You will have to find ways to control any urges to respond negatively to consumers that anger you. A calm and caring response to consumer behavior should have a positive effect on the situation and may give you an opportunity to better understand the consumer's behavior. The consumer may have every reason to be angry. It may help to discuss the consumer's behavior with your supervisor. Your supervisor may be able to help you find ways to respond effectively both to the consumer's behavior and to your own reaction to it.

Challenging Behavior

Sometimes, behavior is not predictable or appropriate in our opinion. These behaviors are difficult for us to deal with. At times, we may not know what certain behaviors mean or why the consumer is doing it. At other times, the behavior involves conflict with us or someone else. In fact, there is a range of behaviors we find difficult to deal with. They are listed below:

1. **Conflict** ~ disagreement between two persons usually involving angry or hostile approaches.
2. **Annoying Behaviors** ~ repetitive or provocative behaviors that are time consuming to deal with but do not compromise safety or threaten injury.
3. **Aggressive Behaviors** ~ sometimes called a crisis where consumer is out of control and the behavior exhibited is explosive.

Annoying Behaviors: Definition, Examples and Approach

These are provocative, repetitive, nuisance behaviors exhibited by a consumer that, while difficult and time-consuming, do not compromise safety or threaten injury. Some examples might be:

- Provoking other consumers to create a reaction.
- Asking staff the same question over and over.
- Engaging in behaviors that demand staff attention.
- Complaining of imaginary illnesses or discomforts.
- Breaking rules repeatedly for effect.
- Repeatedly telling lengthy stories of personal misfortune.
- Making repetitive gestures or noises.

Aggressive Behaviors: Definition, Examples and Approach

Aggressive Behaviors are those behaviors in which the consumer is experiencing such internal discomfort that they are out of control. Some persons might term this a crisis or “melt down”. There are many types of aggressive behavior. One consumer may become abusive to himself and bite his arm until it bleeds. Another consumer may throw furniture or other items. Another may stand, scream, and then run away. Another may be using a weapon such as a knife or piece of broken glass in a threatening manner. No matter what type it is or what it is called, aggressive behavior is potentially dangerous and serious.

Other Challenging Behaviors

Consumers may exhibit other behaviors that may or may not be a result of their illness and may require other types of intervention on your part:

- Restlessness
- Rummaging
- Hoarding

- Wandering
- Resisting services
- Suspiciousness
- Paranoia
- Lack of initiative
- Delusional behavior
- Other non-compliant behaviors such as smoking, drinking to excess or use of illegal drugs.

The main purpose of such acts is usually unknown to the staff. However, some common purposes of this type of behavior are to:

- Draw attention to the consumer.
- Engage staff and others in interaction.
- Cause staff to do something they otherwise would not do.
- Gain sympathy.
- Test the impact of one's behavior.
- Add interest to situations that seem meaningless.
- Provide self-stimulation.
- Respond to an inner stimulus or feeling.
- Be a symptom of an underlying medical disorder.

Interventions

How staff members react will determine whether such acts are brief and transient or continue and become worse. Your thoughtful response will make a difference.

Interventions for Annoying Behaviors

Staff responses to these types of behavior should be direct, clear, patient and helpful, but brief. You may need to try a variety of these scenarios to find out what works for the consumer. At such moments, staff need to:

- Acknowledge the communication supportively.
- Determine if a serious source of discomfort exists.
- Offer reassurance and clarification if necessary.
- Terminate conversation politely and move on.
- Redirect the consumer to another activity.
- Validation (confirming the reality of the consumer's situation as seen by the consumer).
- Reality Orientation (reorienting the consumer to the reality of the situation as you see it).

Since many of these behaviors are done for attention or engagement, staff should not spend a lot of time focusing on them. Staff should deal with the behavior and move on. If staff spend a great deal of time discussing the

behavior and paying attention to it, then the behavior is reinforced and most likely will continue in the future. These behaviors may indicate that the consumer needs more attention from staff. Staff may wish to provide more attention to the consumer in a more positive way.

Interventions for Aggressive Behaviors

Skill is required to handle aggressive behaviors. If you are working with individuals who go into crisis, your employer will teach you techniques to use in such situations. You must use the specific techniques required by your agency. The principles below are of a general nature and are not intended to substitute for such training:

First, recognize that behavior in this category usually is not planned, not rational, and not under the person's control. Staff should put aside notions such as "he could stop this kind of acting out if he wanted to." Nobody wants to be out of control. It is scary. When dealing with a person who is out of control, it's no exaggeration to say that we, as staff members, must think both for ourselves and for the affected person. As professionals, we must behave rationally, cautiously, and helpfully to effectively manage the situation. The primary consideration is safety. This means that all our actions should first be directed at avoiding physical injury and promoting psychological comfort for everyone involved.

You may help to assure the safety of others by:

- Quickly removing other consumers and staff from area.
- Summon extra help if needed.
- Get a natural barrier between you and the consumer.
- If possible, get potential weapons out of reach.

In addition, in working with an individual who is exhibiting aggressive behavior you need to quickly assess the situation. Before you do anything, you should ask yourself the following questions:



- What's going on here?
- What do I know about this person who is feeling so distressed and confrontational?
- Is there a history of prior events that might explain this consumer's aggression now?
- In what sort of physical environment is this situation taking place?
- Do I have an escape route if I need to use it?
- Are there objects in the room that might be used as weapons against me? Against the consumer by him/herself?
- Are there natural barriers between this consumer and me, such as a sofa or chair that might slow down any assaultive behavior?

- Is the potentially assaultive person sitting or standing; remaining still or moving about?
- Are there other consumers present who might be hurt if physical aggression occurs, or who might join in an altercation?
- Are other staff members present or nearby if I need assistance?
- What tactics will I use if I cannot calm the troubled person?

One may have only seconds or minutes to answer such questions, but doing so may prevent injury or loss of life. At the very least, answering such questions allows you to enter the situation more intelligently and skillfully.

Second, as a staff member, you must remember that the minute you begin interacting with an aggressive consumer, you are part of the situation. How you behave will have a direct, and often profound, influence on how things turn out. Just as you can help by doing things such as being calm and reducing stimuli; you can also make the situation much worse by yelling or moving quickly and with force.

Third, you must learn, in advance, how best to operate with difficult, aggressive individuals. You must be prepared to think on your feet, drawing on prior learning and your sense of the situation. You won't have an opportunity in the midst of a crisis to learn those techniques you should have acquired earlier. Begin now.

Fourth, you will be much more effective in crisis situations if you remember to avoid trying to gain control of the aggressive consumer and his/her behavior. Overt attempts to control a consumer will provoke further hostility, leading to danger and the possibility of injury. Manage and influence the situation; don't attempt to control the person. Be aware of your own need for control in stressful situations and resist the urge to "take over". If you cannot control this urge, you may wish to allow someone else to deal with the situation.

You might decide that the situation will be best managed by one of the following three techniques: therapeutic hold, brief counseling or police intervention. You do not have long to make a decision about which techniques you will use. Here are some helpful guidelines:

1. Police intervention is appropriate when the consumer is out of control, has a weapon, is holding hostages, or is too big for you to deal with.
2. Therapeutic holds are appropriate when the consumer is out of control and in danger of hurting himself and others, but can be managed by staff. There are a variety of techniques that are used which include Nappi and Mandt. In this situation, staff will move quickly to physically restrain the consumer until he/she is calmed down. If therapeutic holding is used, verbal communication should be minimal. Your agency will provide training if these methods are to be used.

3. Brief counseling is used for all other occasions. In **brief counseling**, you are creating a short-term relationship with a troubled person to helping her deal with aggressive feelings. This is very different from trying to control that person. In any professional care relationship, we are concerned with attending to the person, bonding with her, confirming that we hear her needs, confirming key feelings and expressing support for seeking a solution. Here you are doing this under conditions of stress, anger, high emotion and potentially assaultive behavior.

Brief Counseling Technique

In beginning the brief counseling process with a troubled, potentially aggressive person, do these things first:

- Avoid assuming you know what the person feels and what motivates the person. You may, and again, you may not. Mistaken assumptions can hurt you or the consumer.
- Slow down and don't enter the situation hastily. Give yourself as much time as you reasonably can to assess the situation before you plunge in.
- Quickly plan your approach. You need to know what you are going to do.
- Be prepared to change that approach the moment the consumer's behavior suggests it won't work.
- Focus on the working relationship you are trying to create with the aggressive individual. You are attempting to relate, not control.
- Be alert to multiple sources of danger.

When you are ready, use the brief counseling process with the aggressive individual.

1. **Attending**
 - Get on the "same page" with the consumer and let him/her know you are attempting to relate.
2. **Reflecting**
 - Reflect or "bounce back" what you hear the troubled person saying, letting him/her know you've heard his/her distress.
3. **Validating and Confirming**
 - Actively communicate that you hear the consumer's discomfort, its sources, the problem as he sees it, and the frustration or conflict this produces in the person. You are validating the consumer's experience whether you agree with it or not.
 - Communicate understanding.
4. **Fact Finding and Problem Solving**

- Attempt to develop your understanding of what has happened by asking questions (if you can do so non-threateningly) and getting the facts in order to see why this individual has become so upset.
- Engage in as normal a conversation as you can, given the circumstances, with the troubled person, exploring further the situation and what s/he might see as solutions to this difficult situation. As the situation quiets down, problem solving becomes possible.
- Use problem solving to assist the person to solve the immediate problem.
- Possibly suggest moving to another location if this one seems dangerous or inhospitable... and to a calmer discussion of the grievance. Leave this decision up to the consumer.

5. **Summarizing**

- As the interaction winds down and ends, try to summarize what has been said and proposed as a way to change what has happened. You will leave with some clear statement of what is to follow and will work to make it happen. Your credibility depends on it.
- You should also periodically check, in minutes and in hours, how the formerly aggressive person is feeling and behaving.

This method may take from several minutes to even several hours. What matters is that the method de-escalates anger (because the person is, at last, being listened to and validated) and establishes support while looking for solutions that the consumer feels would be helpful.

Human Relationships and Sexual Behavior

Human Relationships

All people need love, belongingness, safety, group affiliation, and self-esteem. These needs can only be fulfilled in relationships with others. This is true for the entire life span.

You have many relationships with others. You may be a daughter or son, mother or father, spouse, friend, worker, partner, coach, and mentor to name a few. Your relationship with your parents assisted you in the development of love, self-care, roles as a man or a woman, and other tasks of your life. Relationships provide security and love but also may provide hurt, shame and embarrassment. Think of all the relationships you have and how they fulfill your needs. Some people have many relationships and others just a few. The fewer relationships we have the more important they are, especially as we age. Loss of relationships is a real psychosocial problem for some persons with disabilities since they may not have had the opportunity to form as many

relationships to start with. Moving into a residential care facility (where most contact is with staff) also decreases the ability to develop and sustain social relationships.

Depending on the job description, the PSS may have opportunities to promote the continuance of established relationships or to assist the consumer with the development of new relationships. Depending on the setting, you may be asked to promote the continuance of already established relationships by some of the following:

1. Encouraging connectedness with the community.
2. Welcoming visitors of the consumer.
3. Developing family oriented activities that include consumer friends and family.
4. Arranging for the consumer to attend family activities.
5. Arranging transportation to clubs and activities that the consumer enjoys.
6. Assisting with correspondence (including use of email).
7. Not getting involved in disputes between family members or friends unless it is exploitive in nature.
8. Maintaining our boundaries in relation to the consumer and his/her social relationships.

We may be asked to assist with the development of new relationships by:

1. Learning about the consumer's likes and dislikes.
2. Finding activities to meet consumer needs.
3. Introducing consumers to people with similar interests.
4. Arranging dining room seating to promote socialization.
5. Bringing volunteer groups into the facility.
6. Encouraging consumer involvement in community.

Sexual Behavior

Another area of potential concern to the PSS is that of intimate relationships between the consumer and others. Intimate relationships and sexuality are normal and predictable aspects of human behavior. Regardless of their surroundings, some persons will have an interest in sexual expression and some will become involved in sexual activity.

Staff members need to examine their own attitudes toward human sexuality. It is inappropriate for you to insist that your own values in such matters become rules for consumers. Each individual, staff or consumer, is entitled to his/her own views of sexuality within the normal constraints generally imposed by society.

The consumer may be involved in sexual activity. It is not your job to judge his/her choices in this area. However, there are certain situations in which intervention on the part of staff may be warranted in order to protect the

consumer from abuse or exploitation. With regard to intervention, basic staff guidelines should revolve around the following concepts:

1. Mutual respect and courtesy in everyday interactions between consumers is insisted upon.
2. Staff members are aware of and protect consumer rights.
3. Staff members prevent teasing or humiliation of persons who may have private, sexual relationships.
4. Staff members comply appropriately with mandates to inform state agencies of illegal sexual behavior.
5. Staff members report inappropriate staff-consumer sexual contact.
6. Staff members protect consumers from unwanted sexual overtures or exploitation.
7. Public displays of sexual interest or behavior are not tolerated.

Sexual involvement between a staff member and a consumer is never appropriate. Staff members are responsible for protecting consumers from such contacts. In addition, staff members must be alert to situations in which their own rights or safety might be compromised. Staff members have a right to protection from sexual overtures, unwanted touching or other sexual behavior by consumers toward staff.

If you have questions about the appropriateness or lawfulness of any sexual behavior in the workplace, you should discuss these questions with your supervisor.

9

Module 9: Concepts of Aging and Illness



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Describe 4 developmental processes associated with aging;
- ➔ Demonstrate the ability to provide appropriate care for consumers with identified illnesses;
- ➔ Identify the pros and cons of using assistive devices; and
- ➔ Define the role of the PSS with regard to death and dying.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Assistive Devices
- Ambulation
- Terminally ill

Developmental Issues/Aging

Note: Refer to the text “Personal Care in the Home” pages 34-35.

In Maine, people may choose to remain where they are and “age in place” rather than going to a long term care facility or other specialized facilities as their needs for care change. This means that providers must find ways to adjust their type and level of service to meet the needs of consumers.

General signs and symptoms of disease conditions that should be reported:

- prolonged weakness
- dizziness
- headaches
- shortness of breath especially upon rest
- rapid breathing
- sweating
- fever or chills
- pain that is not usually controlled by the consumer
- nausea or vomiting
- prolonged coughing especially with yellow, blood-tinged mucous
- blue color to extremities and lips
- excessive thirst and prolonged thirst
- drowsiness after a restful sleep
- puss or unusual discharge
- urine with dark color, strong odor, pinkish color or white sediment
- difficulty urinating
- pain/burning on urination
- urination frequency especially in small amounts.

Assistive Devices

Note: Refer to the text “Personal Care in the Home” pages 36-37.

Note: The use of assistive devices may increase the consumer’s sense of self-esteem. They may also decrease it. This is especially true with elderly consumers for whom the use of a wheelchair or walker may indicate a decrease in ability and independence. While assistive devices may sometimes be seen in a negative way, they do allow the consumer to perform activities with less help from others.

Death and Dying

Note: Refer to the text “Personal Care in the Home” pages 38-39.

10

Module 10: Safety



OBJECTIVES

After completing this module, you will be able to do the following:

- ➡ Describe the role of the PSS related to safety;
- ➡ Demonstrate body mechanics and back safety skills;
- ➡ Demonstrate tasks related to fire safety;
- ➡ Describe the role of the PSS related to crime and self-defense;
- ➡ Demonstrate the steps of infection control;
- ➡ Demonstrate hand washing procedure;
- ➡ Demonstrate procedure for removing gloves; and
- ➡ Describe procedures for handling contaminated material.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Lower back injuries
- Evacuation plan
- Pathogens
- Contagious
- Universal Precautions
- Biohazard
- Double bagging
- Disinfectant

Role of PSS Related to Safety

Note: Refer to the text “Personal Care in the Home” pages 46-47.

Lifting

Note: Refer to the text “Personal Care in the Home” pages 48-49.

Safety Hazards

Note: Refer to the text “Personal Care in the Home” pages 50-53.

Crime

Note: Refer to the text “Personal Care in the Home” pages 54-55.

Self Defense with Regard to Consumer Care

Unfortunately, Personal Support Specialists may occasionally encounter situations in which other persons in the workplace (consumers or other individuals) may become agitated and threatening. In these situations, your own personal safety is your primary concern. Some agencies offer training in how to respond to threatening situations (MANDT and NAPPI are examples of this type of training). Find out what training options your agency offers with regard to self-defense. In general however, if you are in a workplace situation (home or agency-based) that you feel presents a threat to your physical safety, leave the site and contact your supervisor immediately.

Infection Control

Note: Refer to the text “Personal Care in the Home” pages 58-59.

Gloves/Gloves

Note: Refer to the text “Personal Care in the Home” pages 60-63.

Contaminated Material

Note: Refer to the text “Personal Care in the Home” pages 64-65.

11

Module 11: Instrumental Activities of Daily Living



OBJECTIVES

After completing this module, you will be able to do the following:

- Define the role of the PSS with regard to care of the home/room/apartment;
- Define the guidelines for using cleaning products safely;
- Identify the elements required for cleaning a kitchen;
- Identify the elements required for cleaning a bathroom;
- Define the steps involved in making a bed;
- Define the elements involved in laundry cleaning;
- Define the elements of money management;
- Define the elements of shopping;
- Identify the elements of good nutrition;
- Identify the elements of a balanced diet;
- Identify the elements of food safety, including cross contamination, room temperature, food temperature, refrigeration;
- Describe the steps in meal preparation; and
- Describe the steps in serving a meal.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Unit price
- Freshness date
- Nutrients
- Fluid output
- Balanced diet
- Calories
- Cross contamination

CARE OF THE HOME/ROOM/APARTMENT

Note: Refer to the text “Personal Care in the Home” pages 68-69.

Housekeeping

Note: Refer to the text “Personal Care in the Home” pages 70-71.

Cleaning Products

Note: Refer to the text “Personal Care in the Home” pages 72-73.

Note: OSHA Hazardous Chemical Guidelines state that the employee has a right to see the MSDS sheets for all products they are using, and personal protective equipment must be supplied.

Kitchen

Note: Refer to the text “Personal Care in the Home” page 74.

Bathroom

Note: Refer to the text “Personal Care in the Home” page 75.

Many accidents occur in the bathroom and many germs are spread there as well. Maintaining a clean and neat bathroom is necessary to personal hygiene, safety, and infection control.

Bathrooms are used constantly and must be cleaned regularly. Wet surfaces and moisture make a good environment for germs. Wet floors are dangerous. Toilets become dirty with use. A clean bathroom is both pleasant and safe. Be sure to wear gloves at all times. The infection control procedure for cleaning the bathroom is top to bottom (clean to dirty): starting with the mirror, then the sink, then the tub (including adaptive equipment such as grab bars, shower

chairs and bath mat), then the toilet (be sure to use a toilet brush) and then the floor.

Bedroom and Bed making

Note: Refer to the text “Personal Care in the Home” pages 76-79.

Laundry

Note: Refer to the text “Personal Care in the Home” pages 80-81.

Money Management

Note: Refer to the text “Personal Care in the Home” pages 82-83.

Follow your facility’s/agency’s policy on handling money as each provider will have their own rules for this activity. In the community setting and in some residential care facilities, consumers will need you to perform shopping, banking, or other activities involving money. You will be required to carefully account for all money handled and to make sure that consumers get what they need at prices they should pay.

Shopping

Note: Refer to the text “Personal Care in the Home” pages 84-85.

The PSS will frequently “shop” for consumers. When shopping for consumers, follow your agency’s/facility’s policy regarding the purchase of certain products (e.g. tobacco, alcohol, illegal drugs). When health concerns are an issue, check with your supervisor. It is never acceptable to borrow or take anything from a consumer. If you are shopping for a consumer and you are on company time, respect your company’s policy regarding shopping for yourself.

FOOD AND NUTRITION

Note: Refer to the text “Personal Care in the Home” pages 88-89.

The Balanced Diet

Note: Refer to the text “Personal Care in the Home” pages 90-91.

Therapeutic Diets

Occasionally consumers will be on a special diet prescribed by their doctor. Examples of special diets include low salt, no salt, low fat, no fat, low calorie, diabetic, etc. When a consumer has a special diet, there will be a special menu that the consumer should follow for their well being. You should encourage them to follow their diet. Refer to your supervisor if the consumer is not following the recommended diet.

Food Safety

Note: Refer to the text “Personal Care in the Home” pages 92-93.

Meal Preparation

Note: Refer to the text “Personal Care in the Home” pages 94-95.

Serving a Meal

Note: Refer to the text “Personal Care in the Home” pages 96-97.

12

Module 12: Transfers and Activities of Daily Living



OBJECTIVES

After completing this module, you will be able to do the following:

- Define guidelines for transfers.
- Demonstrate the following transfer skills:
 - Transferring from bed; and
 - Transferring to a chair.
- Demonstrate the ability to assist a consumer in walking;
- Define general guidelines for assisting consumers with activities of daily living/personal care; and
- Demonstrate skill in assisting consumers in the following ADL's:
 - Brushing teeth
 - Cleaning dentures
 - Back massage
 - Bathing (tub and bed baths)
 - Perineal Care
 - Shampooing hair
 - Shaving
 - Nail care
 - Dressing and undressing
 - Using a bedpan
 - Using and caring for a hearing aid
 - Caring for eyeglasses
 - See Skills Checklist in Appendix D for any additional skills.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Transferring
- Dangling
- Strong side
- Non-skid footwear
- Transfer board
- Transfer belt
- Ambulation
- Walker
- Incident report
- Universal precautions
- Perineal care
- Weak side

GUIDELINES FOR TRANSFERS

Transfers

Note: Refer to the text “Personal Care in the Home” pages 100-101.

Transferring from Bed

Note: Refer to the text “Personal Care in the Home” pages 102-103.

Transferring to a Chair

Note: Refer to the text “Personal Care in the Home” pages 104-105.

Assisted Walking

Note: Refer to the text “Personal Care in the Home” pages 106-107.

ACTIVITIES OF DAILY LIVING

Activities of Daily Living/Personal Care

Note: Refer to the text “Personal Care in the Home” pages 110-133.

Role of the Staff with Respect to the Health of Consumers

There are two parts to the role of the Personal Support Specialist with respect to the health of the person for whom you are providing support. The first part of the role is know and complete your specific assigned tasks in relationship to the person's health. The second part of the role is to be a good observer and reporter of changes in the person's health status.

Tasks of the PSS with respect to health

Depending on your employer, its organization and your job there, you may do one or all of the tasks identified in this section. You should check your job description to see what your responsibilities are. The following is a list of some of the tasks you might be responsible for:

1. Taking temperature, pulse, respiration, blood pressure and weight
2. Driving the person to medical appointments.
3. Assisting with personal care.
4. Providing formal or informal exercises.
5. Putting on a brace.
6. Using personal protective equipment.
7. Using medical equipment or supplies, such as, lifts, wheelchairs, standing tables, and compression hose
8. Feeding the consumer.
9. Meal preparation.
10. Making medical appointments.
11. Communicating with health care professionals and families.
12. Preventing infection from spreading by using good hand washing skills.
13. Teaching the person to give his or her own medication.
14. Providing emotional support.
15. Assisting with eyeglasses, hearing aids, and other medical appliances.
16. Reporting side effects of medications.
17. Infection control.

Brushing Teeth

Note: Refer to the text "Personal Care in the Home" pages 112-113.

Dentures

Note: Refer to the text “Personal Care in the Home” pages 114-115.

Bed Bath

Note: Refer to the text “Personal Care in the Home” pages 116-119.

Perineal Care

Note: Refer to the text “Personal Care in the Home” pages 120-121.

Tub Baths and Showers

Note: Refer to the text “Personal Care in the Home” pages 122-123.

Shampooing Hair

Note: Refer to the text “Personal Care in the Home” pages 124-125.

Shaving

Note: Refer to the text “Personal Care in the Home” page 126.

Nail Care

Note: Refer to the text “Personal Care in the Home” page 127.

Back Massage

Note: Refer to the text “Personal Care in the Home” pages 128-129.

According to the federal guidelines from the National Institute of Health entitled Clinical practice Standards, massaging DOES NOT PREVENT bedsores. In fact, it may actually cause bedsores/decubitus ulcers.

Dressing and Undressing

Note: Refer to the text “Personal Care in the Home” pages 130-131.

Other Personal Care Services

Offering a Bedpan

Procedure:

1. Preparation
 - A. Gather the following items at bedside:
 - i. Bedpan
 - ii. Toilet paper
 - iii. Small trash bag
 - iv. Disposable pad
 - B. Provide for privacy
 - C. Lower the bed to a flat position
 - D. Put on gloves
2. Ready the Consumer
 - A. Fold back the top sheets so that they are out of the way and cover the genital area
 - B. Remove clothing from waist down
 - C. Ask the person to turn on their side and roll the person onto the bedpan
 - D. Replace the sheet over the person and raise the head of the bed
 - E. Give the person time as needed, leaving the room if possible
 - F. Remove gloves
 - G. When consumer is ready, lower the head of the bed and put on gloves.
 - H. Give peri-care.
 - I. Note areas of redness or rash.
 - J. Help the person to raise their hips or roll the person on their side and remove the bedpan.
 - K. Place the bedpan immediately in a small trash bag.
 - L. Replace clothing
 - M. Make consumer as comfortable as possible.
 - N. Take the trash bag with the bedpan in it and dispose of the contents in a toilet.
 - O. Rinse the bedpan with warm water and spray with bleach-water solution.
 - P. Remove gloves and dispose in trashcan.
 - Q. Wash hands.

Warm the bedpan by running warm water in it and around the rim; then dry it with paper towels.

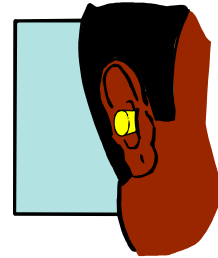
Persons should be encouraged to use the toilet/commode whenever possible. They are more normal forms of toileting.

Hearing Aid Care and Use

- **Tools and equipment:** Hearing Aid, Case, Batteries

Inserting the Hearing Aid:

1. Identify the person and explain that you will be putting in the hearing aid. Ask person if he/she wishes to do it him/herself.
2. Provide privacy by taking consumer into bedroom or bathroom;
3. Wash your hands.
4. Check the ear for wax buildup or anything unusual. If found, do not proceed but notify supervisor.
5. Turn the hearing aid off. Be sure that the hearing aid contains proper size batteries and is functioning.
6. If the person is able, allow him/her to insert hearing aid.
7. If you are inserting the hearing aid, place the hearing aid over the person's ear, if appropriate, with ear mold hanging free.
8. Adjust the hearing aid behind the ear.
9. Gently insert the ear mold into the ear canal. Gently twist the ear mold into the curve of the ear. Push up and in with one hand. Use your other hand to pull gently on the earlobe.
10. Turn the hearing aid on and adjust the volume to a comfortable level.
11. If the person complains that the hearing aid is uncomfortable, remove and reinsert. Report to supervisor the discomfort.
12. Wash your hands after completing the procedure.



Removing the Hearing Aid:

1. Wash your hands
2. Explain to the person that you will be removing his/her hearing aid.
3. Turn off the hearing aid.
4. Gently pull on the upper ear to loosen the outer portion of the hearing aid.
5. Lift the ear mold up and out.
6. Remove the batteries before storing the hearing aid in its container. Make sure the container is labeled with the person's name. Store it in a safe place. Never use a denture cup to store

a hearing aid. Moisture or water in the hearing aid will ruin the amplifying mechanism.

7. Wash your hands.

Caring for the Hearing Aid:

1. Check the batteries before inserting the hearing aid. The battery case should close easily. If it does NOT, the batteries are probably the wrong size.
2. Test the batteries by turning the hearing aid on. Turn up the volume control. When you put the hearing aid next to your ear, you should hear a whistle. That means that it is functioning.
3. Check the batteries if the person says that they cannot hear properly.
4. Do NOT wash the hearing aid.
5. Cleaning must be done by the dealer.
6. Do NOT get the hearing aid wet – remove for bathing, hair washing, swimming, or other activities of this sort.
7. Do NOT expose to heat or moisture.
8. Do NOT get lotions or sprays into hearing aid
9. Remove for sleep, if permitted by consumer.
10. Follow manufacturers directions for cleaning ear molds.

Storing the Hearing Aid:

1. Store in dry container.
2. Remove batteries.
3. Label container with the person's name.

Communicating with someone using a hearing aid:

1. Do not shout.
2. Face the person.
3. Annunciate clearly.
4. Check for understanding.

Caring for Eyeglasses

Procedure:

1. Assemble necessary equipment (a soft cloth and a cleaning solution if needed).
2. Explain to the person what you are going to do.
3. Remove the person's eyeglasses from the case or take them off the person's head. Handle the glasses by the frame only.
4. Inspect the glasses by holding them up to the light and looking for scratches, smears, or loose hinges.
5. Clean the glasses by:



- a. Running them under warm water or using a cleaning solution
 - b. Dry the glasses with a soft cloth
 - c. Avoid the use of scratchy materials like napkins or paper towels.
6. Return the eyeglasses to the person.
7. Wash your hands.

To prevent scratches or breaks, remember to always keep eyeglasses in a case when they are not being worn. Remember to never put glasses with lenses facing downward on a table.

Caring for the Bedbound Consumer

- Bed bath
- Skin care
- Turning consumer's position in bed (every two hours)
- Hourly mouth care (when not taking fluids)
- Assisting with bed pans
- Watching for pressure points
- Making the occupied bed
- Use of side rails
- Feeding procedures
- Incontinence care and products
- Clothing and dressing
- Emotional support

Consumers can become bedbound either temporarily such as during an episode of the flu or pneumonia or permanently when they no longer are safe to transfer. Consumers may spend more time in bed and require a new plan of care in order to avoid the complications of immobility. We were made to move and our total body systems depend on that movement for proper functioning. When we no longer stimulate our systems through this movement we often need caregivers to assist with this stimulation.

There are a variety of procedures you have already learned that will assist you in giving care to a consumer who is bedbound. Those procedures are:

- Bed bath
- Skin care
- Turning consumer's position in bed (every two hours)
- Hourly mouth care (when not taking fluids)
- Assisting with bed pans
- Watching for pressure points
- Making the occupied bed

- Use of side rails
- Feeding procedures
- Incontinence care and products
- Clothing and dressing
- Emotional support

When a consumer is in bed most of the day, the bed-bath takes on great importance. It isn't just for cleansing the skin but also is a source of stimulation for the skin to promote circulation to the skin and extremities. During the bed-bath it is important to observe the skin for complications of immobility most importantly redness. Oftentimes redness will appear when someone has been in the same position for a period of time.

Areas of the body that bear the pressure of the body when lying in one position for an extended period of time are:

- back near the shoulders;
- back of the head;
- elbows;
- hips;
- base of the spine; and
- heels of the feet.

When giving the bed-bath the PSS should observe for these reddened areas and relieve the pressure placed on them as soon as possible. **DO NOT RUB A REDDENED AREA.** Rubbing the area is the old school of thought to increase circulation. In fact, we have found that it instead damages the underlying tissues. After repositioning the consumer watch the reddened area for 10 minutes. If it has not blanched back to its normal color then a stage 1 ulcer has developed and needs to have an evaluation by a professional. Notify your supervisor of any redness that remains after 10 minutes of relief from the body's pressure.

There are many devices on the market to prevent ulcers. Some of these include:

- lambskin pads and heel protectors;
 - foam protectors;
 - moisture absorbing underpads; and
 - plastic pads;
- which can all be placed over the reddened area to act as a "second skin" while the tissue is healing.

Prevention

Prevention is the key. Pillows can be used to support the body parts to prevent the build up of pressure and changing the bedbound consumer's position every 2 hours from side to back to side are the most common forms of prevention.

Massaging the bony prominences of the body during the bath will increase circulation to the tissues and promote their ability to sustain the pressures of the body.

Keeping the skin clean and moisturized preserves its structures and allows it to maintain its protective role for the body.

Other systems

By becoming bedbound the client develops complications of immobility. Systems affected by that immobility are:

1. Muscular

Consumers who are bedbound may have muscle weakness and joint stiffness when first attempting to get out of bed. Range of motion exercises to all extremities on a daily basis will keep their joints flexible. They may be unsteady as well as “lightheaded” which will compound their risk of falling. This is due to changes that take place in their blood pressure while lying in bed for prolonged periods of time.

2. Digestive

Consumers who are bedbound will have problems with their digestive system. They will have difficulty digesting foods and eliminating wastes. A special soft diet and new-bowel regime may be necessary to promote nutrition and elimination. If a consumer is not taking fluids regularly, he/she should have mouth care every hour to keep the mouth moist.

3. Nervous

Being in bed is tiring and can cause depression and feelings of anxiety. If you are giving end of life care, you may be addressing grieving issues with both the consumer and the family.

Infection Control for the Bedbound Consumer

Infection control can take on new meaning with the bedbound consumer especially if there are body wastes or drainage on the bed linens or bedclothes. The use of universal precautions is very important in the protection of you the worker as well as the consumer. Rolling the linens into a ball to trap the bacteria and disposing of them properly can prevent the spread of bacteria. When the consumer is incontinent, all body fluids should be wiped from the body with paper products, which can be easily disposed of in the trash. The body can then be cleansed with commercial cleaning pads or soap and washcloths. Disposing of body fluids first keeps those bacteria out of the laundry. Selecting a certain color washcloth, preferably white distinguishes it from others used for the face and allows bleaching for sanitization. When a consumer is in bed all day, the bed linens should be inspected daily for drainage and odor. Incontinence products can protect the consumer and linens but may leave an odor in the bed and bedroom. The PSS should clean

the equipment used daily especially the wash-basin. Soaking it in bleach and water after use will destroy bacteria in the bath water that might have contaminated the basin.

Caring for a bedbound consumer can be a very rewarding experience as the PSS puts all the various procedures together in a comprehensive plan of care that prevents complications. The family is oftentimes responsible for the consumer's care the remainder of the day and they look to the PSS for guidance in providing that care. Whenever in doubt as to what the care plan encompasses with these consumers, consult your supervisor.

13

Module 13: Consumer Emergencies



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Demonstrate the ability to respond to the following consumer emergencies:
 - Choking;
 - Falls;
 - Hemorrhages;
 - Seizures;
 - Stroke;
 - Poisoning; and
 - Burns.
- ➔ Demonstrate the ability to break a fall.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- | | |
|---------------------|-------------|
| • Assessment | • Seizures |
| • Heimlich Maneuver | • Stroke |
| • Finger sweep | • Poisoning |
| • Hemorrhages | • Burns |

Role of the PSS with Regard to Consumer Emergencies

Note: Refer to the text “Personal Care in the Home” pages 134-147.

14

Module 14: Approaches to Teaching



OBJECTIVES

After completing this module, you will be able to do the following:

- ➔ Identify 6 basic everyday skills that a PSS might teach;
- ➔ Identify and describe the 3 different learning styles;
- ➔ Demonstrate 5 different methods of teaching;
- ➔ Demonstrate the Tell-Show-Do model of teaching; and
- ➔ Demonstrate the ability to list the steps needed to teach skills.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- Visual
- Auditory
- Tactile/kinesthetic
- Modeling
- Demonstration
- Repetition
- Task analysis
- Hand over hand

Learning Styles and Teaching Methods

There are many reasons to teach skills to consumers. People need to keep the skills that they have for as long as they can and they also may need to learn new skills. Some have had injuries, strokes, or other illnesses that require them to learn skills such as walking or talking all over again. Others may never have had the opportunity to learn skills such as washing your own hair, selecting your own wardrobe or preparing your own meals that would increase their independence and improve their quality of life.

Teaching skills may focus on basic, everyday skills like getting dressed, taking a bath, or hair brushing. It may mean teaching someone how to balance a checkbook, use a bus, call a taxi, or make an appointment with the doctor. It may mean teaching someone how to use an artificial leg, send e-mail to a granddaughter, or sit in church quietly. For some people, it means learning how to control anger, start a conversation, or live with a roommate for the first time.

We will talk in more specifics later in this training about the need for each consumer to have a service plan. That service plan may include skills that need to be supported and maintained as well as skills that need to be learned by the consumer. Your job as a PSS is to create opportunities for teaching skills and, as much as you can, to encourage the people with whom you work to do as much for themselves as they can. Although sometimes it may seem quicker to “do it myself”, this doesn’t help the person learn, relearn, or use the skills he already has.

A. Learning Styles

Each of us has a style of learning that may be different from that of other people with whom we live and work. The same is true of all people. In fact, some people may never learn to perform the task on their own, but will be able to perform tasks by watching you do it. As a PSS, you will need to be flexible and observant in order to figure out how someone best learns. Some typical ways or modalities that people use to learn are the following:

➤ Visual

People who learn best this way like to watch something being done before they try it. They may want to read the instructions or directions before trying a new skill. Having a picture or diagram to look at may be a real help.



➤ **Auditory**

Hearing someone else talk about how to do something is how some people learn best. They can hear the instructions from a staff person, the radio, a tape, or by overhearing someone else's conversation.



➤ **Tactile/Kinesthetic**

This style of learning is accomplished by doing the task. People who learn best this way like to get their hands into the project or skill they are learning and just try to do it.



B. Methods of Teaching

We can teach through a variety of methods. The following are some of the more common methods for teaching consumers:

➤ **Modeling**

Modeling means that your behavior always models a proper way of doing something. It is important that what you say and what you do correspond. Example: washing your hands after going to the bathroom.



➤ **Demonstration**

This method of teaching intends to show the consumer how a skill is done. This is different from modeling where the teaching may not be intentional.

Example: How to fry an egg.



➤ **Repetition**

Once someone has learned a skill, it is important to repeat that successful learning over and over again. Learning something once and then not using the skill again for days or weeks may make it more difficult for the person to keep the skill.

Example: How to use the washing machine properly.



➤ **Task Analysis**

Task analysis is a way of breaking big skills into many smaller pieces so that the consumer may learn each piece before moving on to the entire skill. Teaching someone to use a washing machine can be broken into a series of small steps which, when put all together in the correct order, results in using the washing machine



independently. This is much easier for many consumers than being expected to master the entire skill at one time.
Example: Putting on clothes in the proper order.

➤ **Hand over hand**

This way of teaching is rare in work with elderly consumers but common in working with people who have mental retardation. This work involves actually moving someone's hands, fingers, arms, legs, or feet through the steps of the skills that are being taught.
Example: Brushing teeth or getting an Alzheimer's consumer to feed him or her self.



C. Motivation

Knowing how someone learns and a variety of methods for teaching are background information for teaching a skill. More important than either of these is the person's motivation to learn. If the consumer does not want to learn the skill that you are teaching, he or she won't learn it. If the consumer wants to learn the task, you have a better probability of success.

A consumer may be motivated to learn a skill in order to reach a goal that is important to him or her. For example, learning to buy groceries every week or how to make coffee in the morning is exciting for someone who wants to be more independent. Someone else may be motivated to learn how to use e-mail in order to stay in touch with grandchildren who live far away.

The service plan should include goals that are meaningful to the consumer. Once these goals have been identified, it will be much easier for you to know that you are working on skills that are important and motivating to the consumer. You may need to remind the consumer of their motivation sometimes.

D. Tell-Show-Do

The **Tell-Show-Do** method of teaching skills is a widely accepted way of teaching anyone skills. It incorporates motivation, learning style, and teaching methods. It is easy to remember the steps and works for many different situations.

Before starting to teach a skill, determine what the person already knows about the skill. If you know what the person can already do, then it gives you some ideas about where you should begin. For example, if you are teaching someone to use a washing machine who doesn't know how to open the machine, you would start your skill teaching there. If the

consumer knew everything except how to sort colors before washing, that's where you would start.

TELL Step

You should begin by telling the person what the skill is that they are going to be learning. Describe what you will be doing to teach the skill. Remind her why she wanted to learn this skill. Describe what she should be able to do when she has learned the skill. (This step is particularly important to people who are auditory learners.)

SHOW Step

You show the person how to do the skill. You can use pictures, diagrams, props, or real situations. Break the skill into manageable amounts of information. (This step is particularly important for people who are visual learners.)

DO Step

Encourage the person to do what you have told her and shown her. You may need to give reminders. You may realize that the way you showed doesn't really work for this person; back up and demonstrate another way. Give plenty of positive encouragement. Be careful not to say "no" or "that's not right" or other negative comments. However, that doesn't mean that you never provide correction in this process. It is important not to be negative but to offer no correction means that the person may continue to perform the skill incorrectly. Don't expect perfection the first time she tries to do what you showed her. (This step is particularly important for people who are tactile learners.)

Be ready to repeat the tell-show-do sequence over and over again. It is unlikely that most people will be able to master a skill with just one repetition. Be patient and encourage the person by reminding him or her about what they learned each time they repeated the sequence.

You may think that it would be hard for you to teach someone how to do something that you don't know how to do yourself. This may be an opportunity for you to work together with the person to figure out how to do it. It may also be a time for you to ask someone else to help you learn the skill so that you can pass it on.

Teaching a skill which makes someone more independent or satisfied is some of the most important work that you will do as a PSS. Make the time to do this and you will benefit as well.

15

Module 15: Procedures



OBJECTIVES

After completing this module, you will be able to do the following:

- ➞ Demonstrate skill in the following types of cath-care:
 - Indwelling; and
 - Supra-pubic.
- ➞ Demonstrate skill in care of feeding tubes;
- ➞ Demonstrate skill in taking vital signs;
- ➞ Demonstrate skill in ostomy care;
- ➞ Demonstrate skill in reminding consumers to take medication; and
- ➞ Demonstrate skill in measuring intake and output.



VOCABULARY

After completing this module, you should be familiar with the following terms:

- | | |
|----------------|---------------|
| • Catheter | • Vital signs |
| • Cath-care | • Ostomy |
| • Indwelling | • Intake |
| • Supra-pubic | • Output |
| • Feeding tube | |

A

Appendix A: Consumer Rights

1: A Consumer's Bill of Rights

A Consumer's Bill of Rights was first adopted by the American Hospital Association (AHA) in 1973.

This revision was approved by the AHA Board of Trustees on October 21, 1992.

Introduction

Effective health care requires collaboration between consumers and physicians and other health care professionals. Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to optimal consumer care. As the setting for the provision of health services, hospitals must provide a foundation for understanding and respecting the rights and responsibilities of consumers, their families, physicians, and other caregivers. Hospitals must ensure a health care ethic that respects the role of consumers in decision-making about treatment choices and other aspects of their care. Hospitals must be sensitive to cultural, racial, linguistic, religious, age, gender, and other differences as well as the needs of persons with disabilities.

The American Hospital Association presents A Consumer's Bill of Rights with the expectation that it will contribute to more effective consumer care and be supported by the hospital on behalf of the institution, its medical staff, employees, and consumers. The American Hospital Association encourages health care institutions to tailor this bill of rights to their consumer community by translating and/or simplifying the language of this bill of rights as may be necessary to ensure that consumers and their families understand their rights and responsibilities.

Bill of Rights

These rights can be exercised on the consumer's behalf by a designated surrogate or proxy decision maker if the consumer lacks decision-making capacity, is legally incompetent, or is a minor.

- The consumer has the right to considerate and respectful care.
- The consumer has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable

information concerning diagnosis, treatment, and prognosis.

- Except in emergencies when the consumer lacks decision-making capacity and the need for treatment is urgent, the consumer is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.
- Consumers have the right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, consumers, or other trainees. The consumer also has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.
- The consumer has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of the medical consequences of this action. In case of such refusal, the consumer is entitled to other appropriate care and services that the hospital provides or transfer to another hospital. The hospital should notify consumers of any policy that might affect consumer choice within the institution.
- The consumer has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by law and hospital policy.
- Health care institutions must advise consumers of their rights under state law and hospital policy to make informed medical choices, ask if the consumer has an advance directive, and include that information in consumer records. The consumer has the right to timely information about hospital policy that may limit its ability to implement fully a legally valid advance directive.
- The consumer has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each consumer's privacy.
- The consumer has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The consumer has the right to expect that the hospital will emphasize the confidentiality of this

information when it releases it to any other parties entitled to review information in these records.

- The consumer has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The consumer has the right to expect that, within its capacity and policies, a hospital will make reasonable response to the request of a consumer for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a consumer has so requested, a consumer may be transferred to another facility. The institution to which the consumer is to be transferred must first have accepted the consumer for transfer. The consumer must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.
- The consumer has the right to ask and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence the consumer's treatment and care.
- The consumer has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct consumer involvement, and to have those studies fully explained prior to consent. A consumer who declines to participate in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.
- The consumer has the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic consumer care options when hospital care is no longer appropriate.
- The consumer has the right to be informed of hospital policies and practices that relate to consumer care, treatment, and responsibilities. The consumer has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, consumer representatives, or other mechanisms available in the institution. The consumer has the right to be informed of the hospital's charges for services and available payment methods.

The collaborative nature of health care requires that consumers, or their families/surrogates, participate in their care. The effectiveness of care and consumer satisfaction with the course of treatment depends, in part, on the

consumer fulfilling certain responsibilities. Consumers are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision-making, consumers must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information and instructions. Consumers are also responsible for ensuring that the health care institution has a copy of their written advance directive if they have one. Consumers are responsible for informing their physicians and other caregivers if they anticipate problems in following prescribed treatment.

Consumers should also be aware of the hospital's obligation to be reasonably efficient and equitable in providing care to other consumers and the community. The hospital's rules and regulations are designed to help the hospital meet this obligation. Consumers and their families are responsible for making reasonable accommodations to the needs of the hospital, other consumers, medical staff, and hospital employees. Consumers are responsible for providing necessary information for insurance claims and for working with the hospital to make payment arrangements, when necessary.

A person's health depends on more than health care services. Consumers are responsible for recognizing the impact of their life-style on their personal health.

2: The Residents' Bill of Rights

The Nursing Home Reform Act established the following rights for nursing home residents:

- **Free choice:** The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.
- **Free from restraints:** The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed –
 - * To ensure the physical safety of the resident or other residents, and

- * Only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).
- **Privacy:** The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.
- **Confidentiality:** The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.
- **Accommodation of needs:** The right –
 - * To reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; and
 - * To receive notice before the room or roommate of the resident in the facility is changed.
- **Grievances:** The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.
- **Participation in resident and family groups:** The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.
- **Participation in other activities:** The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.
- **Examination of survey results:** The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.
- **Refusal of certain transfers:** The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of

subchapter XVIII of this chapter) to a portion of the facility that is such a skilled nursing facility.

- **Other rights:** Any other right established by the Secretary. Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

3: Consumer Bill of Rights for Home-Based Care

Federal law requires that all individuals receiving home care services be informed of their rights as a consumer. Following is a model consumer bill of rights the National Association for Home Care (NAHC) has developed, based on the consumer rights currently enforced by law:

Home care consumers have the right to:

1. Be fully informed of all his or her rights and responsibilities by the homecare agency;
2. Choose care providers;
3. Appropriate and professional care in accordance with physician orders;
4. Receive a timely response from the agency to his or her request for service;
5. Be admitted for service only if the agency has the ability to provide safe, professional care at the level of intensity needed;
6. Receive reasonable continuity of care;
7. Receive information necessary to give informed consent prior to the start of any treatment or procedure;
8. Be advised of any change in the plan of care, before the change is made;
9. Refuse treatment within the confines of the law and to be informed of the consequences of his or her action;
10. Be informed of his or her rights under state law to formulate advanced directives;
11. Have health care providers comply with advance directives in accordance with state law requirements;
12. Be informed within reasonable time of anticipated termination of service or plans for transfer to another agency;
13. Be fully informed of agency policies and charges for services, including eligibility for third-party reimbursements;
14. Be referred elsewhere, if denied service solely on his or her inability to pay;
15. Voice grievances and suggest changes in service or staff without fear of restraint or discrimination;
16. A fair hearing for any individual to whom any service has been denied, reduced, or terminated, or who is otherwise aggrieved by agency action.

The fair hearing procedure shall be set forth by each agency as appropriate to the unique consumer situation (i.e., funding source, level of care, diagnosis);

17. Be informed of what to do in the event of an emergency;
18. Be advised of the telephone number and hours of operation of the state's home health hot line, which receives questions and complaints about Medicare-certified and state-licensed home care agencies.

*National Association for Home Care
228 Seventh Street, SE
Washington, DC 20003*

4: Rights of Residents in Assisted Living Facilities

The Department of Human Services Regulations Governing the Licensing and Functioning of Assisted Living Facilities identifies the following rights for people living in residential care:

In addition to the rights enumerated below, the applicant/licensee shall provide ongoing evidence that the policies and practices in the Assisted Living Services Program promote and encourage the exercise of resident rights, opportunity to age in place and right to informed choice.

- **Freedom of choice of provider.** For services and supplies not provided by the Assisted Living Services Program, each resident has the right to select the provider of his/her choice. A provider may not impede a resident's freedom of choice.
- **Rights regarding transfer and discharge.** Each resident has the right to continued residence whenever a valid contract for services is in force. The facility must show documented evidence of strategies used to prevent involuntary transfers or discharges. A resident shall not be transferred or discharged involuntarily, except for the following reasons:
 - * The Assisted Living Services Program has provided documented evidence that a resident has violated the admission contract obligations, despite reasonable attempts at problem resolution;
 - * A resident's continued tenancy constitutes a direct threat to the health or safety of others;

- * A resident's intentional behavior has resulted in substantial physical damage to the property of the Assisted Living Services Program or others residing in or working there;
 - * A resident has not paid for his/her residential services in accordance with the contract between the Assisted Living Services Program and the resident;
 - * In order for the resident to remain in the Assisted Living Services Program, the provider would have to modify the essential nature of the program; or
 - * The Assisted Living Services Program has had its license revoked, not renewed, or voluntarily surrendered.
- **Transfer or discharge.** When an Assisted Living Services Program transfers or discharges a resident in a non-emergency situation, the resident or his/her guardian shall be provided with at least thirty (30) days advance written notice to ensure adequate time to find an alternative placement that is safe and appropriate. The provider has an affirmative responsibility to assist in the transfer or discharge process and to produce a safe and orderly discharge plan. If no discharge plan is possible, then no involuntary non-emergency discharge shall occur until a safe discharge plan is in place. Appropriate information, including copies of pertinent records, shall be transferred with a resident to a new placement. Each notice must be written and include the following:
- * The reason for the transfer or discharge, including events which are the basis for such action;
 - * The effective date of the transfer or discharge;
 - * Notice of the resident's right to appeal the transfer or discharge as set forth in Section;
 - * The mailing address and telephone number of the Long Term Care Ombudsman Program;
 - * In the case of residents with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocacy, Behavioral and Developmental Services;
 - * The resident's right to be represented by himself/herself or by legal counsel, a relative, friend, or other spokesperson.

- **Emergency transfer or discharge.** When an emergency situation exists, no written notice is required, but such notice as is practical under the circumstance shall be given to the resident and/or resident's representative. The facility shall assist the resident and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement and the Assisted Living Services Program's obligation in regard to such assistance does not necessarily terminate. [IV]
- **Leaves of absence.** When a resident is away from the Assisted Living Services Program and continues to pay for services in accordance with the contract, the resident shall be permitted to return to the Assisted Living Services Program unless any of the reasons set forth in Section 4020 are present and the resident or resident's legal representative has been given notice as may be required in these regulations.
- **Assistance in finding alternative placement.** Residents who choose to relocate shall be given assistance by the Assisted Living Services Program.
 - * Residents of Level I, Level I Plus and Level II Residential Care Facilities shall not be required to give advance notice. Advance notice of relocation shall not be required in order to obtain a refund.
 - * Congregate Housing Services Programs may request up to a ten (10)-calendar day notice for residents choosing to relocate in order to obtain a refund. For those residents who relocate for emergency medical treatment no advance notice is required to obtain a refund.
 - * The Assisted Living Services Program shall provide information to the resident regarding potential risks that may be inherent in the discharge plan and information that will support the resident's adjustment to his/her next residential setting. [IV]
- **Right to communicate grievances and recommend changes.** Residents shall be encouraged and assisted to exercise their rights as residents and citizens. They may freely communicate grievances and recommend changes in policies and services to the staff of the Assisted Living Services Program and to outside representatives of their choice, without restraint, interference, coercion, discrimination or reprisal. All grievances shall be documented. Assisted Living Services Programs shall establish and implement a procedure for the timely review and disposition of grievances. The procedure shall include a written response to the grievant describing disposition of the complaint. These documents shall be maintained and available for review upon request by the Department. [IV]

- **Right to manage financial affairs.** Residents shall manage their own financial affairs, unless there is a representative payee, other legal representative appointed or other person designated by the resident. [IV]
- **Right to freedom from abuse, neglect or exploitation.** Residents shall be free from mental, verbal, physical and/or sexual abuse, neglect and exploitation. [IV]
- **Rights regarding restraints and aversive conditioning.** There shall be no use of physical, chemical, psychological, or mechanical restraints or aversive conditioning, except in accordance with this Section.
 - * Full-length bedrails on both sides of the bed are considered restraints and shall not be attached to the bed. Half-length bedrails attached to the top half of the bed are permissible.
 - * In the case of a person with mental retardation, the Assisted Living Services Program complies with the requirements of the Regulations Governing the Use of Behavioral Procedures in Maine Programs Serving Persons with Mental Retardation and the Regulations Governing the Use of Restraints in Community Settings. These regulations are promulgated and enforced by Behavioral and Developmental Services (BDS). Failure to comply with these regulations will be considered by the Department when evaluating any application for licensure or renewal, in amending, modifying, or any other action against an existing licensee, or in a decision to invoke fines or other sanctions.
 - * For any resident who is a consumer of BDS due to his/her mental illness, the Assisted Living Services Program complies with the Rights of Recipients of Mental Health Services, promulgated and enforced by BDS. Failure to comply with those regulations will be considered by the Department when evaluating any application for licensure or renewal, in amending, modifying, or any other action against an existing licensee, or in a decision to invoke fines or other sanctions.
- **Right to confidentiality.** Residents' records and information kept by the Assisted Living Services Program pertaining to his/her personal, medical and mental health status is confidential. Residents and their legal representatives shall have access to all records pertaining to the resident at reasonable times, in the presence of the provider or his/her representative, within twenty-four (24) hours of the request. Residents are entitled to have copies made of their record within twenty-four (24) hours of the request. The licensee and employees shall have access to confidential information about each resident only to the extent needed to carry out the requirements of the licensing regulations. The written consent of the resident or his/her

legal representative shall be required for release of information to any other party except authorized representatives of the Department or the Long Term Care Ombudsman Program. The Department shall have access to these records for determining compliance with these regulations. Records shall not be removed from the Assisted Living Services Program, except as may be necessary to carry out these regulations. Upon admission to the Assisted Living Services Program or within thirty (30) calendar days of the effective date of these regulations for all current residents who have not already been given this information, each resident shall be asked for a signed, dated and specific written consent which lists individuals with whom the program may share information (e.g., family members, duly authorized licensed practitioners, visiting nurses, etc.). Consent may be withdrawn at any time.

- **Right to refuse to perform services for the facility.** Residents may refuse to perform services for the Assisted Living Services Program.
- **Right to privacy and consideration.** Residents shall be treated with consideration and respect in full recognition of their dignity and individuality, including privacy in treatment and in care for personal needs, preferred language and communication modes, and ADLs.
- **Right to communicate privately with persons of choice.** Residents may associate and communicate privately with persons of their choice, unless to do so would infringe on the rights of others. They may receive personal mail, unopened, and shall be assisted when necessary with writing and mailing letters and making phone calls.
- **Right to participate in activities of choice.** Residents may participate in social, political, religious and community activities, unless to do so would infringe on the rights of others.
- **Right to personal clothing and possessions.** Residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents. The Assisted Living Services Program shall allow and encourage residents to use their own furnishings, space permitting.
- **Right to privacy when visiting or talking on the telephone.** Residents shall have privacy when visiting with family, friends, and/or spouse and when having telephone conversations. A couple, who are both residents of the Assisted Living Services Program, has the right to share a room.
- **Right to be informed of services provided by the Assisted Living Services Program.** Residents shall be fully informed of items or services that are included in the rate they pay for residential services. Residents

shall not be charged for repair or replacement of items damaged by normal wear and tear.

- **Right to refuse treatment or services.** Residents may choose to refuse medications, treatments, or any services offered by the Assisted Living Services Program. If the resident refuses necessary care or treatment, the Assisted Living Services Program shall make reasonable efforts to consult the resident's duly authorized licensed practitioner, caseworker or other appropriate individuals in order to ensure that residents receive necessary services. However, in no case shall a person who does not have legal authority to do so, order treatment which has not been consented to by a competent resident.
- **Right to be free from discrimination.** A resident shall be provided services without regard to race, age, national origin, religion, disability, gender, or sexual orientation.
- **Right to information regarding the Assisted Living Services Program's deficiencies.** Residents have the right to be fully informed of findings of the most recent survey conducted by the Department. The Assisted Living Services Program shall inform residents or their legal representatives that the survey results are public information and are available in a common area of the facility. Residents and their legal representatives shall be notified by the Assisted Living Services Program of any actions proposed or taken against the Assisted Living Services Program by the Department, including but not limited to, decisions to issue Conditional licenses, refusal to renew a license, appointment of a receiver or to impose fines or other sanctions. This notification shall take place within fifteen (15) working days from receipt of notice of action.
- **Notification of rights.** The Assisted Living Services Program shall inform each resident and legal representative prior to or at admission or within thirty (30) calendar days of any changes to Section 4000, of these rights and shall provide them with a copy thereof. The Assisted Living Services Program must accommodate for any communication barriers that may exist, to ensure that each resident is fully informed of his/her rights.
- **Bill of rights for persons with mental retardation.** Assisted Living Services Programs serving persons with mental retardation shall post and comply with the Bill of Rights for Persons with Mental Retardation, Title 34-B M.R.S.A. § 5601 et. seq.
- **Mandatory report of rights violations.** Any person or professional who provides health care, social services or mental health services or who administers a long term care facility or program who believes that the regulations pertaining to residents' rights and the conduct of resident care

have been violated, shall report the alleged violation to the Division of Licensing and Certification and to one or more of the following:

- Disability Rights Center (DRC), pursuant to Title 5 M.R.S.A. § 19501 through § 19508 for incidents involving persons with mental illness; the Long Term Care Ombudsman Program, pursuant to Title 22 M.R.S.A. § 5107-A for incidents involving older persons; the Office of Advocacy, pursuant to Title 34-B M.R.S.A. § 1205 for incidents involving persons with mental retardation; or Adult Protective Services, pursuant to Title 22 M.R.S.A. § 3470 through § 3487.
- Reporting suspected abuse, neglect and exploitation is mandatory in all cases. Documentation shall be maintained in the facility that a report has been made.
- Required reporters shall contact the Division of Licensing and Certification within one (1) working day of having information about the rights violations.
- **Reasonable modifications and accommodations.** To afford individuals with disabilities the opportunity to reside in an Assisted Living Services Program, the Assisted Living Services Program shall:
 - * Permit reasonable modification of the existing premises, at the expense of the disabled individual or other willing payer. Where it is reasonable to do so, the Assisted Living Services Program may require the disabled individual to return the facility to the condition that existed before the modification, upon discharge of that individual. The provider is not required to make the modification at his/her own expense, if it imposes a financial burden.
 - * Make reasonable accommodation in regulations, policies, practices or services, including permitting reasonable supplementary services to be brought into the Assisted Living Services Program. The provider is not required to make the accommodation, if it imposes an undue financial burden or results in a fundamental change in the program.
- **Right of action.** In addition to any remedies contained herein, any resident of an Assisted Living Services Program whose rights have been violated may commence a civil action in Superior Court for injunctive and declaratory relief pursuant to Title 22 M.R.S.A. § 7948 et. seq.
- **Right to appeal an involuntary transfer or discharge.** The resident has the right to an administrative hearing to appeal an involuntary transfer or discharge. The resident must file an appeal within five (5) days of receipt of a written notice of discharge or transfer. If the resident has already been discharged on an emergency basis, the provider shall hold a space available

for the resident pending receipt of an administrative decision. The administrative hearing will be held within thirty (30) days of receipt of an appeal. Requests for appeals shall be submitted to Assisted Living Licensing Services for submission to the Office of Administrative Hearings, 11 State House Station, Augusta, Maine 04333-0011.

- **Resident adjudicated incompetent.** In the case of a resident adjudicated incompetent or who is considered by the resident's attending physician to be incompetent, the rights of the resident are exercised by the resident's legal representative, as defined in Section 1310 of these Regulations.
- **Visitation rights.** The resident has the right to receive visitors at any time.
- **Resident councils**
 - * In any Residential Care Facility five (5) beds or larger, residents have the right to establish a resident council, pursuant to Title 22 M.R.S.A. § 7923. Residents and their families shall be notified of this right, orally and in writing, within the first month after admission, in a manner understood by each resident and by a notice of the right to form a council being posted prominently in the admitting area.
 - * If a majority of the residents choose not to establish a council, they shall be given the opportunity to choose otherwise at least once each year thereafter.
 - * The council has the following rights:
 - To be provided with a copy of the facility's policies and procedures relating to resident rights and to make recommendations to the administrator on how they may be improved;
 - To establish procedures that will ensure that all residents are informed about and understand their rights;
 - To elicit and disseminate information regarding programming in the facility and to make recommendations for improvement;
 - To help identify residents' problems and recommend ways to ensure early resolution;
 - To inform the administrator of the opinions and concerns of the residents;
 - To find ways of involving the families and residents of the facility;
 - To notify the Department and Long Term Care Ombudsman Program when the council is constituted; and
 - To disseminate records of council meetings and decisions to the residents and the administrator and to make these records

available to family members or their designated representatives and the Department, upon request.

- **Right to a service plan.** The resident has the right to expect the provider to assist him/her in implementing any reasonable plan of service developed with community or state agencies. [IV]

5: Rights and Basic Protections of a Person with Mental Retardation or Autism

A person with mental retardation or autism is entitled to the following rights and basic protections.

- **Humane treatment.** A person with mental retardation or autism is entitled to dignity, privacy, and humane treatment.
- **Practice of religion.** A person with mental retardation or autism is entitled to religious freedom and practice without any restriction or forced infringement on that person's right to religious preference and practice.
- **Communications.** A person with mental retardation or autism is entitled to private communications.
 - * A person with mental retardation or autism is entitled to receive, send, and mail sealed, unopened correspondence. A person who owns or is employed by a day facility or a residential facility may not delay, hold or censor any incoming or outgoing correspondence of any person with mental retardation or autism, nor may any such correspondence be opened without the consent of the person or the person's legal guardian.
 - * A person with mental retardation or autism in a residential facility is entitled to reasonable opportunities for telephone communication.
 - * A person with mental retardation or autism is entitled to an unrestricted right to visitations during reasonable hours, except that nothing in this provision may be construed to permit infringement upon others' rights to privacy.
- **Work.** A person with mental retardation or autism engaged in work programs that require compliance with state and federal wage and hour laws is entitled to fair compensation for labor in compliance with regulations of the United States Department of Labor.

- **Vote.** A person with mental retardation or autism may not be denied the right to vote for reasons of mental illness, as provided in the Constitution of Maine, Article II, Section 1, unless under guardianship.
- **Personal property.** A person with mental retardation or autism is entitled to the possession and use of that person's own clothing, personal effects and money, except that, when necessary to protect the person or others from imminent injury, the chief administrator of a day facility or a residential facility may take temporary custody of clothing or personal effects, which the administrator shall immediately return when the emergency ends.
- **Nutrition.** A person with mental retardation or autism in a residential facility is entitled to nutritious food in adequate quantities and meals may not be withheld for disciplinary reasons.
- **Medical care.** A person with mental retardation or autism is entitled to receive prompt and appropriate medical and dental treatment and care for physical and mental ailments and for the prevention of any illness or disability, and medical treatment must be consistent with the accepted standards of medical practice in the community, unless the religion of the person with mental retardation or autism so prohibits.
 - * Medication may be administered only at the written order of a physician.
 - * Medication may not be used as punishment, for the convenience of staff, as a substitute for a habilitation plan or in unnecessary or excessive quantities.
 - * Daily notation of medication received by each person with mental retardation or autism in a residential facility must be kept in the records of the person with mental retardation or autism.
 - * Periodically, but no less frequently than every 6 months, the drug regimen of each person with mental retardation or autism in a residential facility must be reviewed by the attending physician or other appropriate monitoring body, consistent with appropriate standards of medical practice.
 - * All prescriptions must have a termination date.
 - * Pharmacy services at each residential facility operated by the department must be directed or supervised by a professionally competent pharmacist licensed according to the provisions of Title 32, chapter 41.
 - * Prior to instituting a plan of experimental medical treatment or carrying out any surgical procedure, express and informed consent must be obtained from the person with mental retardation or autism, unless the person has been found to be legally incompetent, in which case the person's guardian may consent.

- Before making a treatment or surgical decision, the person must be given information, including, but not limited to, the nature and consequences of the procedures, the risks, benefits and purposes of the procedures and the availability of alternate procedures.
 - The person or, if legally incompetent, that person's guardian may withdraw express and informed consent at any time, with or without cause, before treatment or surgery.
- * Notwithstanding the absence of express and informed consent, emergency medical care or treatment may be provided to any person with mental retardation or autism who has been injured or who is suffering from an acute illness, disease or condition if delay in initiation of emergency medical care or treatment would endanger the health of the person.
 - * Notwithstanding the absence of express and informed consent, emergency surgical procedures may be provided to any person with mental retardation or autism who has been injured or who is suffering from an acute illness, disease or condition if delay in initiation of emergency surgery would substantially endanger the health of the person.
- **Sterilization.** A person with mental retardation or autism may not be sterilized, except in accordance with chapter 7.
 - **Social activity.** A person with mental retardation or autism is entitled to suitable opportunities for behavioral and leisure time activities that include social interaction.
 - **Physical exercise.** A person with mental retardation or autism is entitled to opportunities for appropriate physical exercise, including the use of available indoor and outdoor facilities and equipment.
 - **Discipline.** Discipline of persons with mental retardation or autism is governed as follows.
 - * The chief administrative officer of each facility shall prepare a written statement of policies and procedures for the control and discipline of persons receiving services that is directed to the goal of maximizing the growth and development of persons receiving services.
 - Persons receiving services are entitled to participate, as appropriate, in the formulation of the policies and procedures.
 - Copies of the statement of policies and procedures must be given to each person receiving services and, if the person has

been adjudged incompetent, to that person's parent or legal guardian.

- Copies of the statement of policies and procedures must be posted in each residential and day facility.

- * Corporal punishment or any form of inhumane discipline is not permitted.
- * Seclusion is not permitted.

➤ **Behavioral treatment.** Behavioral treatment of a person with mental retardation or autism is governed as follows.

- * A person with mental retardation or autism may not be subjected to a treatment program to eliminate dangerous or maladaptive behavior without first being examined by a physician to rule out the possibility that the behavior is organically caused.
- * Behavioral treatment programs may contain both behavior modification and behavior management components. Behavior modification components consist of interventions designed to assist a person with mental retardation or autism to learn to replace dangerous or maladaptive behavior with safer and more adaptive behavior. Behavior management components consist of systematic strategies to prevent the occurrence of dangerous or maladaptive behaviors by minimizing or eliminating environmental or other factors that cause those behaviors.
- * Treatment programs involving the use of noxious or painful stimuli or other aversive or severely intrusive techniques may be used only to correct behavior more harmful to the person with mental retardation or autism than is the treatment program and only:
 - On the recommendation of a physician, psychiatrist or psychologist; and
 - With the approval, following a case-by-case review, of the chief administrative officer of the residential facility; a representative of the person's residence, day program or work site; an advocate of the department; a representative of the Division of Mental Retardation; and a representative of the Consumer Advisory Board.

➤ **Physical restraints.** Persons with mental retardation or autism are entitled to be free from physical restraints, which include totally enclosed cribs and barred enclosures, but physical restraints may be employed only in emergencies to protect the person from imminent injury to that person or others.

- * Physical restraints may not be used as punishment, for the convenience of the staff or as a substitute for habilitative services.

- * Physical restraints may impose only the least possible restrictions consistent with their purpose and must be removed when the emergency ends.
 - * Physical restraints may not cause physical injury to the person receiving services and must be designed to allow the greatest possible comfort and safety.
 - * Mechanical supports used in normative situations to achieve proper body position and balance are not considered restraints, but mechanical supports must be prescriptively designed and applied under the supervision of a qualified professional with concern for principles of good body alignment, circulation and allowance for change of position.
 - * A device whose effect is to reduce or inhibit a person's movement in any way but whose purpose is to maintain or ensure the safety of the person is not considered behavioral treatment. Such a device may be used only in conformity with applicable state and federal rules and regulations, when recommended by a qualified professional after approval of the person's service plan and when use of the device is approved by the chief administrative officer of the residential care facility; a representative of the person's residence, day program or work site; an advocate of the department; a representative of the Division of Mental Retardation; and a representative of the Consumer Advisory Board.
 - * Daily reports on the use of restraints must be made to the appropriate chief administrative officer of the facility. The report must be reported to the department in any manner required by the department.
 - The reports must summarize all cases involving the use of restraints, the type of restraints used, the duration of usage and the reasons for the usage.
 - A monthly summary of the reports must be relayed to the Office of Advocacy.
- **Records.** All records of persons receiving services must remain confidential as provided in section 1207.
- a. The person with mental retardation or autism or, if the person is incompetent, a parent or guardian is entitled to have access to the records upon request.
 - b. The commissioner is entitled to have access to the records of a day facility or a residential facility if necessary to carry out the statutory functions of the commissioner's office.

B

Appendix B: Ethical Standards

Ethical Standards of Human Service Workers

Adapted from: National Organization for Human Service Education Council for Standards in Human Service Education.

Preamble

Human Services is a profession developing in response to and in anticipation of the direction of human needs and human problems in the late twentieth century. Characterized particularly by an appreciation of human beings in all of their diversity, human services offers assistance to its consumers within the context of their community and environment. Human service professionals, regardless of whether they are students, faculty, or practitioners, promote and encourage the unique values and characteristics of human services. In so doing human service professionals uphold the integrity and ethics of the profession, partake in constructive criticism of the profession, promote consumer and community well being, and enhance their own professional growth.

The ethical guidelines presented are a set of standards of conduct that the human service professional considers in ethical and professional decision-making. It is hoped that these guidelines will be of assistance when the human service professional is challenged by difficult ethical dilemmas. Although ethical codes are not legal documents, they may be used to assist in the adjudication of issues related to ethical human service behavior.

Human service professionals function in many ways and carry out many roles. They enter into professional-consumer relationships with individuals, families, groups, and communities who are all referred to as "consumers" in these standards. Among their roles are caregiver, case manager, broker, teacher/educator, behavior changer, consultant, outreach professional, mobilizer, advocate, community planner, community change organizer, evaluator and administrator. The following standards are written with these multifaceted roles in mind.

➤ The Human Service Professional's Responsibility to Consumers

STATEMENT 1

Human service professionals negotiate with consumers the purpose, goals, and nature of the helping relationship prior to its onset as well as inform consumers of the limitations of the proposed relationship.

STATEMENT 2

Human service professionals respect the integrity and welfare of the consumer at all times. Each consumer is treated with respect, acceptance, and dignity.

STATEMENT 3

Human service professionals protect the consumer's right to privacy and confidentiality except when such confidentiality would cause harm to the consumer or others, when agency guidelines state otherwise, or under other stated conditions (e.g., local, state, or federal laws). Professionals inform consumers of the limits of confidentiality prior to the onset of the helping relationship.

STATEMENT 4

If it is suspected that danger or harm may occur to the consumer or to others as a result of a consumer's behavior, the human service professional acts in an appropriate and professional manner to protect the safety of those individuals. This may involve seeking consultation, supervision, and/or breaking the confidentiality of the relationship.

STATEMENT 5

Human service professionals protect the integrity, safety, and security of consumer records. All written consumer information that is shared with other professionals, except in the course of professional supervision, must have the consumer's prior written consent.

STATEMENT 6

Human service professionals are aware that in their relationships with consumers power and status are unequal. Therefore they recognize that dual or multiple relationships may increase the risk of harm to, or exploitation of, consumers, and may impair their professional judgment. However, in some communities and situations it may not be feasible to avoid social or other nonprofessional contact with consumers. Human service professionals support the trust implicit in the helping relationship by avoiding dual relationships that may impair professional judgment, increase the risk of harm to consumers or lead to exploitation.

STATEMENT 7

Sexual relationships with current consumers are not considered to be in the best interest of the consumer and are prohibited. Sexual relationships with previous consumers are considered dual relationships and are addressed in Statement 6 (above).

STATEMENT 8

The consumer's right to self-determination is protected by human service professionals. They recognize the consumer's right to receive or refuse services.

STATEMENT 9

Human service professionals recognize and build on consumer strengths.

➤ **The Human Service Professional's Responsibility to the Community and Society**

STATEMENT 10

Human service professionals are aware of local, state, and federal laws. They advocate for change in regulations and statutes when such legislation conflicts with ethical guidelines and/or consumer rights. Where laws are harmful to individuals, groups, or communities, human service professionals consider the conflict between the values of obeying the law and the values of serving people and may decide to initiate social action.

STATEMENT 11

Human service professionals keep informed about current social issues as they affect the consumer and the community. They share that information with consumers, groups, and community as part of their work.

STATEMENT 12

Human service professionals understand the complex interaction between individuals, their families, the communities in which they live, and society.

STATEMENT 13

Human service professionals act as advocates in addressing unmet consumer and community needs. Human service professionals provide a mechanism for identifying unmet consumer needs, calling attention to these needs, and assisting in planning and mobilizing to advocate for those needs at the local community level.

STATEMENT 14

Human service professionals represent their qualifications to the public accurately.

STATEMENT 15

Human service professionals describe the effectiveness of programs, treatments, and/or techniques accurately.

STATEMENT 16

Human service professionals advocate for the rights of all members of society, particularly those who are members of minorities and groups at which discriminatory practices have historically been directed.

STATEMENT 17

Human service professionals provide services without discrimination or preference based on age, ethnicity, culture, race, disability, gender, religion, sexual orientation, or socioeconomic status.

STATEMENT 18

Human service professionals are knowledgeable about the cultures and communities within which they practice. They are aware of multiculturalism in society and its impact on the community as well as individuals within the community. They respect individuals and groups, their cultures and beliefs.

STATEMENT 19

Human service professionals are aware of their own cultural backgrounds, beliefs, and values, recognizing the potential for impact on their relationships with others.

STATEMENT 20

Human service professionals are aware of sociopolitical issues that differentially affect consumers from diverse backgrounds.

STATEMENT 21

Human service professionals seek the training, experience, education and supervision necessary to ensure their effectiveness in working with culturally diverse consumer populations.

➤ **The Human Service Professional's Responsibility to colleagues**

STATEMENT 22

Human service professionals avoid duplicating another professional's helping relationship with a consumer. They consult with other professionals who are assisting the consumer in a different type of relationship when it is in the best interest of the consumer to do so.

STATEMENT 23

When a human service professional has a conflict with a colleague, he or she first seeks out the colleague in an attempt to manage the problem. If necessary, the professional then seeks the assistance of supervisors, consultants, or other professionals in efforts to manage the problem.

STATEMENT 24

Human service professionals respond appropriately to unethical behavior of colleagues. Usually this means initially talking directly with the colleague and, if no resolution is forthcoming, reporting the colleague's behavior to supervisory or administrative staff and/or to the Professional organization(s) to which the colleague belongs.

STATEMENT 25

All consultations between human service professionals are kept confidential unless to do so would result in harm to consumers or communities.

➤ **The Human Service Professional's Responsibility to the Profession**

STATEMENT 26

Human service professionals know the limit and scope of their professional knowledge and offer services only within their knowledge and skill base.

STATEMENT 27

Human service professionals seek appropriate consultation and supervision to assist in decision-making when there are legal, ethical, or other dilemmas.

STATEMENT 28

Human service professionals act with integrity, honesty, genuineness, and objectivity.

STATEMENT 29

Human service professionals promote cooperation among related disciplines (e.g., psychology, counseling, social work, nursing, family and consumer sciences, medicine, education) to foster professional growth and interests within the various fields.

STATEMENT 30

Human service professionals promote the continuing development of their profession. They encourage membership in professional associations, support research endeavors, foster educational advancement, advocate for appropriate legislative actions, and participate in other related professional activities.

STATEMENT 31

Human service professionals continually seek out new and effective approaches to enhance their professional abilities.

➤ **The Human Service Professional's Responsibility to Employers**

STATEMENT 32

Human service professionals adhere to commitments made to their employers.

STATEMENT 33

Human service professionals participate in efforts to establish and maintain employment conditions that are conducive to high quality consumer services. They assist in evaluating the effectiveness of the agency through reliable and valid assessment measures.

STATEMENT 34

When a conflict arises between fulfilling the responsibility to the employer and the responsibility to the consumer, human service professionals advise both of the conflict and work conjointly with all involved to manage the conflict.

➤ **The Human Service Professional's Responsibility to Self**

STATEMENT 35

Human service professionals strive to personify those characteristics typically associated with the profession (e.g., accountability, respect for others, genuineness, empathy, pragmatism).

STATEMENT 36

Human service professionals foster self-awareness and personal growth in themselves. They recognize that when professionals are aware of their own values, attitudes, cultural background, and personal needs, the process of helping others is less likely to be negatively impacted by those factors.

STATEMENT 36

Human service professionals recognize a commitment to lifelong learning and continually upgrade knowledge and skills to serve the populations better.

Code of Ethics for Nurses

The American Nurses Association approved these nine provisions of the new *Code of Ethics for Nurses* at its June 30, 2001 meeting in Washington, DC.

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every

individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse's primary commitment is to the consumer, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the consumer.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum consumer care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

C

Appendix C: Safety for Older Consumers

Safety

For Older Consumers



Home Safety Checklist

U.S. Consumer Product Safety Commission June 1986

General Safety

☒ CHECK ALL ELECTRICAL CORDS

QUESTIONS

Are lamp, extension, and telephone cords placed out of the flow of traffic?

YES ☐ NO ☐

Are cords out from beneath furniture and rugs or carpeting?

YES ☐ NO ☐

Are cords attached to the walls, baseboards, etc. with nails or staples?

YES ☐ NO ☐

Are electrical cords in good condition, not frayed or cracked?

YES ☐ NO ☐

Do extension cords carry more than their proper load, as indicated by the ratings labeled on the cord and the appliance?

YES ☐ NO ☐

RECOMMENDATIONS

Cords stretched across walkways may cause someone to trip.

- Arrange furniture so that outlets are available for lamps and appliances without the use of extension cords.
- If you must use an extension cord, place it on the floor against a wall where people cannot trip over it.
- Move the phone so that telephone cords will not lie where people walk.

Furniture resting on cords can damage them, creating fire and shock hazards. Electric cords, which run under carpeting, may cause a fire.

- Remove cords from under furniture or carpeting.
- Replace damaged or frayed cords.

Nails or staples can damage cords, presenting fire and shock hazards.

- Remove nails, staples, etc.
- Check wiring for damage.
- Use tape to attach cords to walls or floors.

Damaged cords may cause a shock or fire.

- Replace frayed or cracked cords.

Overloaded extension cords may cause fires. Standard 18 gauge extension cords can carry 1250 watts.

- If the rating on the cord is exceeded because of the power requirements of one or more appliances being used on the cord, change the cord to a higher rated one or unplug some appliances;
- If an extension cord is needed, use one having sufficient amp or wattage rating.

☒ **CHECK ALL RUGS, RUNNERS AND MATS**

QUESTION

Are all small rugs and runners slip-resistant?

YES ☐ NO ☐

RECOMMENDATIONS

CPSC estimates that in 1982, over 2500 people 65 and over were treated in hospital emergency rooms for injuries that resulted from tripping over rugs and runners. Falls are also the most common cause of fatal injury for older people.

- Remove rugs and runners that tend to slide.
- Apply double-faced adhesive carpet tape or rubber matting to the backs of rugs and runners.
- Purchase rugs with slip-resistant backing.

- Check rugs and mats periodically to see if backing needs to be replaced.
- Place rubber matting under rugs. (Rubber matting that can be cut to size is available.)
- Purchase new rugs with slip-resistant backing.

NOTE: Over time, adhesive on tape can wear away. Rugs with slip-resistant backing also become less effective as they are washed. Periodically, check rugs and mats to see if new tape or backing is needed.

☒ CHECK THE TELEPHONE AREA

QUESTIONS

Are emergency numbers posted on or near the telephone?

YES ☐ NO ☐

Does the consumer have access to a telephone if he/she falls (or experience some other emergency which prevents them from standing and reaching a wall phone)?

YES ☐ NO ☐

RECOMMENDATIONS

In case of emergency, telephone numbers for the Police, Fire Department, and local Poison Control Center, along with a neighbor's number, should be readily available.

- Write the numbers in large print and tape them to the phone, or place them near the phone where they can be seen easily.
- Have at least one telephone located where it would be accessible in the event of an accident that leaves you unable to stand.

☒ CHECK SMOKE DETECTORS

QUESTIONS

Are smoke detectors properly located?

YES ☐ NO ☐

Do you have properly working smoke detectors?

YES ☐ NO ☐

RECOMMENDATIONS

At least one smoke detector should be placed on every floor of your home.

- Read the instructions that come with the smoke detector for advice on the best place to install it.
- Make sure detectors are placed near bedrooms, either on the ceiling or 6-12 inches below the ceiling on the wall.
- Locate smoke detectors away from air vents.

Many home fire injuries and deaths are caused by smoke and toxic gases, rather than the fire itself. Smoke detectors provide an early warning and can wake you in the event of a fire.

- Purchase a smoke detector if you do not have one.
- Check and replace batteries and bulbs according to the manufacturer's instructions.
- Vacuum the grillwork of your smoke detector.
- Replace any smoke detectors that can not be re aired.

NOTE: Some fire departments or local governments will provide assistance in acquiring or installing smoke detectors.

☒ CHECK ELECTRICAL OUTLETS AND SWITCHES

QUESTIONS

Are any outlets and switches unusually warm or hot to the touch?

YES ☐ NO ☐

Do all outlets and switches have cover plates, so that no wiring is exposed?

YES ☐ NO ☐

RECOMMENDATIONS

Unusually warm or hot outlets or switches may in fact cause injury.

- Unplug cords from outlets and do not use the switches
- Have an electrician check the wiring as soon as possible.

Exposed wiring presents a shock hazard.

- Add a cover plate.

☒ CHECK LIGHT BULBS

QUESTIONS

Are light bulbs the appropriate size and type for the lamp or fixture?

YES ☐ NO ☐

RECOMMENDATIONS

A bulb of too high wattage or the wrong type may lead to fire through overheating. Ceiling fixtures, recessed lights, and "hooded" lamps will trap heat.

- Replace with a bulb of the correct type and wattage. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)

☒ CHECK SPACE HEATERS

QUESTIONS

Are heaters that come with a 3-prong plug being used in a 3-hole outlet or with a properly attached adapter?

YES ☐ NO ☐

Are small stoves and heaters placed where they cannot be knocked over, and away from furnishings and flammable materials, such as curtains or rugs?

YES ☐ NO ☐

If your home has space heating equipment, such as a kerosene heater, do you understand the installation and operating instructions thoroughly?

YES ☐ NO ☐

RECOMMENDATIONS

The grounding feature provided by a 3-hole receptacle or an adapter for a 2-hole receptacle is a safety feature designed to lessen the risk of shock.

- Never defeat the grounding feature.
- If you do not have a 3-hole outlet, use an adapter to connect the heater's 3-prong plug. Make sure the adapter ground wire or tab is attached to the outlet.

Heaters can cause fires or serious burns if they cause you to trip or if they are knocked over.

- Relocate heaters away from passageways and flammable materials such as curtains, rugs, furniture, etc.

Unvented heaters should be used with room doors open or window slightly open to provide ventilation. The correct fuel, as recommended by the manufacturer, should always be used. Vented heaters should have proper venting, and the venting system should be checked frequently. Improper venting is the most frequent cause of carbon monoxide poisoning, and older consumers are at special risk.

- Review the installation and operating instructions.
- Call you local fire department if you have additional questions.

☒ CHECK WOODBURNING HEATING EQUIPMENT

QUESTIONS

Is wood-burning equipment installed properly?

YES ☐ NO ☐

RECOMMENDATIONS

Wood-burning stoves should be installed by a qualified person according to local building codes.

- Local building code officials or fire marshals can provide requirements and recommendations for installation.

NOTE: Some insurance companies will not cover fire losses if wood stoves are not installed according to local codes.

☒ CHECK THE EMERGENCY EXIT PLAN

QUESTIONS

Do you have an emergency exit plan and an alternate emergency exit plan in case of a fire?

YES ☐ NO ☐

RECOMMENDATIONS

Once a fire starts, it spreads rapidly. Since you may not have much time to get out and there may be a lot of confusion, it is important that everyone knows what to do.

- Develop an emergency exit plan.
- Choose a meeting place outside your home so you can be sure that everyone has escaped.
- Practice the plan from time to time to make sure everyone is capable of escape quickly and safely.

* Remember periodically to re-check your home.

Safety Checklist for the Kitchen

In the kitchen, check the range area, all electrical cords, lighting, the step stool, all throw rugs and mats, and the telephone area.

☒ CHECK THE RANGE AREA

QUESTIONS

Are towels, curtains, and other things that might catch fire located away from the range?

YES ☐ NO ☐

Do you wear clothing (with short or close-fitting sleeves) while you are cooking?

YES ☐ NO ☐

Are kitchen ventilation systems or range exhausts functioning properly and are they in use while you are cooking?

YES ☐ NO ☐

RECOMMENDATIONS

Placing or storing non-cooking equipment like potholders, dishtowels, or plastic utensils on or near the range may result in fires or burns. Store flammable and combustible items away from range and oven. Remove any towels hanging on oven handles. If towels hang close to a burner, change the location of the towel rack. If necessary, shorten or remove curtains that could brush against heat sources. CPSC estimates that 70% of all people who die from clothing fires are over 65 years of age. Long sleeves are more likely to catch fire than are short sleeves. Long sleeves are also more apt to catch on pot handles, overturning pots and pans and causing scalds.

- Roll back long, loose sleeves or fasten them with pins or elastic bands while you are cooking.

Indoor air pollutants may accumulate to unhealthful levels in a kitchen where gas or kerosene-fired appliances are in use.

- Use ventilation systems or open windows to clear air of vapors or smoke.

☒ **CHECK ELECTRICAL CORDS**

QUESTIONS

Are all extension cords and appliance cords located away from the sink or range areas?

YES ☐ NO ☐

RECOMMENDATIONS

Electrical appliances and power cords can cause shock or electrocution if they come in contact with water. Cords can also be damaged by excess heat.

- Move cords and appliances away from sink areas and hot surfaces.
- Move appliances closer to wall outlets or to different outlets so you won't need extension cords.
- If extension cords must be used, install wiring guides so that cords will not hang near sink, range, or working areas.
- Consider adding new outlets for convenience and safety; ask your electrician to install outlets equipped with ground fault circuit interrupters (GFCIs) to protect against electric shock. A GFCI is a shock-protection device that will detect electrical fault and shut off electricity before serious injury or death occurs.

For more information on cords, refer to the beginning of the checklist.

☒ **CHECK LIGHTING**

QUESTIONS

Does good, even lighting exist over the stove, sink, and countertop work areas, especially where food is sliced or cut?

YES ☐ NO ☐

RECOMMENDATIONS

Low lighting and glare can contribute to burns or cuts. Improve lighting by:

- Opening curtains and blinds (unless this causes too much glare).

- Using the maximum wattage bulb allowed by the fixture. (If you do not know the correct wattage for the fixture, use a bulb no larger than 60 watts.)
- Reducing glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing the blinds or curtains.
- Installing additional light fixtures, e.g. under cabinet/over countertop lighting.

* (Make sure that the bulbs you use are the right type and wattage for the light fixture.)

☒ **CHECK STEP STOOL**

QUESTIONS

Do you have a step stool which is stable and in good repair?

YES ☐ NO ☐

RECOMMENDATIONS

Standing on chairs, boxes, or other makeshift items to reach high shelves can result in falls. CPSC estimates that in 1982, 1500 people over 65 were treated in hospital emergency rooms when they fell from chairs on which they were standing.

- If you don't have a step stool, consider buying one. Choose one with a handrail that you can hold onto while standing on the top step.
- Before climbing on any step stool, make sure it is fully opened and stable.
- Tighten screws and braces on the step stool.
- Discard step stools with broken parts.
- Remember: Check all of the product areas mentioned at the beginning of the checklist.

Safety Checklist for the Living Room and Family Room

In the living room/family room, check all rugs and runners, electrical and telephone cords, lighting, the fireplace and chimney, the telephone area, and all passageways.

☒ CHECK FIREPLACE AND CHIMNEY

QUESTIONS

Are the chimneys clear from accumulation of leaves, or other debris that can clog them?

YES ☐ NO ☐

Has the chimney been cleaned within the past year?

YES ☐ NO ☐

RECOMMENDATIONS

A clogged chimney can cause a poorly burning fire to result in poisonous fumes and smoke coming back into the house.

- Do not use the chimney until the blockage has been removed.
- Have the chimney checked and cleaned by a registered or licensed professional.

Burning wood can cause a build up of a tarry substance (creosote) inside the chimney. This material can ignite and result in a serious chimney fire.

- Have the chimney checked and cleaned by a registered or licensed professional.

☒ CHECK PASSAGEWAYS

QUESTIONS

Are hallways, passageways between rooms, and other heavy traffic areas well lit?

YES ☐ NO ☐

Are exits and passageways kept clear?

YES ☐ NO ☐

RECOMMENDATIONS

Shadowed or dark areas can hide tripping hazards.

- Use the maximum wattage bulb allowed by the fixture. (If you do not know the correct wattage, use a bulb no larger than 60 watts.)
- Install night-lights.
- Reduce glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing blinds or curtains.

Furniture, boxes, or other items could be an obstruction or tripping hazard, especially in the event of an emergency or fire:

- Rearrange furniture to open passageways and walkways.
- Remove boxes and clutter.

Remember: Check all of the product areas mentioned at the beginning of the checklist.

Safety Checklist for the Bathroom

In the bathroom, check bathtub and shower areas, water temperature, rugs and mats, lighting, small electrical appliances, and storage areas for medications.

☒ CHECK BATHTUB AND SHOWER AREAS

QUESTIONS

Are bathtubs and showers equipped with non-skid slip mats, abrasive strips, or surfaces that are not slippery?

YES ☐ NO ☐

RECOMMENDATIONS

Wet, soapy tile surfaces are slippery and may contribute to falls. Apply textured strips or appliques on the floors of tubs and showers.

- Use non-skid mats in the tub or shower, and on the bathroom floor.
- If you are unstable on your feet, use a stool with a non-skid surface, or grab bars in your shower can help prevent falls.
- Check existing bars for strength and stability, and repair if necessary.

☒ CHECK THE WATER TEMPERATURE

QUESTIONS

Is the water temperature 120 degrees or lower?

YES ☐ NO ☐

RECOMMENDATIONS

Water temperature above 120 degrees can cause tap water scalds. Lower the setting on your hot water heater to "Low" or 120 degrees. If you are unfamiliar with the controls of your water heater, ask a qualified person to adjust it for you. If your hot water system is controlled by your landlords, ask them to consider lowering the setting.

NOTE: If the water heater does not have a temperature setting, you can use a thermometer to check the temperature of the water at the tap.

- Always check water temperature by hand before entering bath or shower.
- Taking baths, rather than showers, reduces the risk of a scald from suddenly changing water temperatures.

☒ CHECK LIGHTING

QUESTIONS

Is a light switch located near the entrance to the bathroom?

YES ☐ NO ☐

RECOMMENDATIONS

A light switch near the door will prevent you from walking through a dark area.

- Install a night-light. Inexpensive lights that plug into outlets are available.
- Consider replacing the existing switch with a "glow switch" that can be seen in the dark.

☒ **CHECK SMALL ELECTRICAL APPLIANCES**

QUESTIONS

Are small electrical appliances such as hair dryers, shavers, curling irons, etc. unplugged when not in use?

YES ☐ NO ☐

RECOMMENDATIONS

Even an appliance that is not turned on, such as a hairdryer, can be potentially hazardous if it is left plugged in. If it falls into water in a sink or bathtub while plugged in, it could cause a lethal shock.

- Unplug all small appliances when not in use.
- Never reach into water to retrieve an appliance that has fallen in without being sure the appliance is unplugged.
- Consider installing a ground fault circuit interrupter (GFCI) in your bathroom outlet to protect against electric shock.

☒ **CHECK MEDICATIONS**

QUESTIONS

Are all medicines stored in the containers that they came in and are they clearly marked?

YES ☐ NO ☐

RECOMMENDATIONS

Medications that are not clearly and accurately labeled can be easily mixed up. Taking the wrong medicine or missing a dosage of medicine you need can be dangerous.

- Be sure that all containers are clearly marked with the contents, doctor's instructions, expiration date, and consumer's name.
- Dispose of outdated medicines properly.
- Request non child-resistant closures from your pharmacist only when you cannot use child-resistant closures.

NOTE:

Many poisonings occur when children visiting grandparents go through the medicine cabinet or grandmother's purse. In homes where grandchildren or other youngsters are frequent visitors, medicines should be purchased in containers with child-resistant caps, and the caps properly closed after each use. Store medicines beyond the reach of children.

Safety Checklist for the Bedroom

In the bedroom, check all rugs and runners, electrical and telephone cords, and areas around beds.

☒ CHECK AREAS AROUND BEDS

QUESTIONS

Are lamps or light switches within reach of each bed?

YES ☐ NO ☐

Do you ever go to sleep with a heating pad that is turned on?

YES ☐ NO ☐

Is there a telephone close to your bed?

YES ☐ NO ☐

RECOMMENDATIONS

Lamps or switches located close to each bed will enable people getting up at night to see where they are going.

- Rearrange furniture closer to switches or move lamps closer to beds.
- Install night-lights.

Never go to sleep with a heating pad if it is turned on because it can cause serious burns even at relatively low settings.

In case of an emergency, it is important to be able to reach the telephone without getting out of bed.

Remember: Check all of the product areas mentioned at the beginning of the checklist.

Safety Checklist for the Basement, Garage, Workshop, and Storage Areas

In the basement, garage, workshop, and storage areas, check lighting, fuse boxes or circuit breakers, appliances and power tools, electrical cords, and flammable liquids.

QUESTIONS

Are work areas, especially areas where power tools are used, well lit?

YES ☐ NO ☐

Can you turn on the lights without first having to walk through a dark area?

YES ☐ NO ☐

RECOMMENDATIONS

Power tools were involved in over 5200 injuries treated in hospital emergency rooms to people 65 and over in 1982. Three fourths of these were finger injuries. Good lighting can reduce the chance that you will accidentally cut your finger.

Either install additional light, or avoid working with power tools in the area. Basements, garages, and storage areas can contain many tripping hazards and sharp or pointed tools that can make a fall even more hazardous.

- Keep an operating flashlight handy.
- Have an electrician install switches at each entrance to a dark area.

Replacing a correct size fuse with a larger size fuse can present a serious fire hazard.

☑ CHECK FLAMMABLE AND VOLATILE LIQUIDS

QUESTIONS

Are containers of volatile liquids tightly capped?

YES ☐ NO ☐

RECOMMENDATIONS

If not tightly closed, vapors may escape that may be toxic when inhaled. Check containers periodically to make sure they are tightly closed.

NOTE: CPSC has reports of several cases in which gasoline, stored as much as 10 feet from a gas water heater, exploded. Many people are unaware that gas fumes can travel that far.

☑ CHECK FLAMMABLE AND VOLATILE LIQUIDS

QUESTIONS

Are gasoline, paints, solvents, or others products that give off vapors or fumes stored away from ignition?

RECOMMENDATIONS

Gasoline, kerosene, and other flammable liquids should be stored, out of living areas in properly labeled, non-safe containers

Safety Checklist for Stairs

For all stairways, check lighting, handrails, and the condition of the steps and coverings.

QUESTIONS

Are stairs well lighted?

YES ☐ NO ☐

Are light switches located at both the top and bottom of inside stairs?

YES ☐ NO ☐

RECOMMENDATIONS

Stairs should be lighted so that each step, particularly the step edges, can be clearly seen while going up and down stairs. The lighting should not produce glare or shadows along the stairway.

Use the maximum wattage bulb allowed by the light fixture. (If you do not know the correct wattage, use a bulb larger than 60 watts.)

Reduce glare by using frosted bulbs, indirect lighting, shades or globes on light fixtures, or partially closing blinds and curtains.

Have a qualified person add additional light fixtures. Make sure that the bulbs you use are the right type and wattage for the light fixture.

Even if you are very familiar with the stairs, lighting is an important factor in preventing falls. You should be able to turn on the lights before you use the stairway from either end.

If no other light is available, keep an operating flashlight in a convenient location at the top and bottom of the stairs.
Install night-lights at nearby outlets.

Consider installing switches at the top and bottom of the stairs.

☒ CHECK THE HANDRAILS

QUESTIONS

Are sturdy handrails fastened securely on both sides of the stairway?

YES ☐ NO ☐

Do the handrails run continuously from the top to the bottom of the entire flight of stairs?

YES ☐ NO ☐

Are the coverings on the steps in good condition?

YES ☐ NO ☐

Can you clearly see the edges of the steps?

YES ☐ NO ☐

Is anything stored on the stairway, even temporarily?

YES ☐ NO ☐

RECOMMENDATIONS

The handrail should provide a comfortable grip and should always be used when climbing up or going down the steps.

- Repair broken handrails.
- Tighten fixtures that hold handrails to the wall.
- If no handrails are present, install at least one handrail (on the right side as you face down the stairs).

If the handrail doesn't extend continuously the full length of the stairs, people who are not aware of this might think they have come to the last step when the handrail stops. Misjudging the last step can cause a fall. A handgrip should be available for even one step.

- While using the stairs, try to remember that if the handrail begins beyond the first step or ends before the last step, you must be especially careful.
- Replace a short handrail with a longer one.

Worn treads or worn or loose carpeting can lead to insecure footing, resulting in slips or falls.

Worn or torn coverings or nails sticking out from coverings could snag your foot or cause you to trip.

Falls may occur if the edges of the steps are blurred or hard to see.

- Paint edges of outdoor steps white to see them better at night.

- Add extra lighting.
- If you plan to carpet your stairs, avoid deep pile carpeting or patterned or dark colored carpeting that can make it difficult to see the edges of the steps clearly.

D

Appendix D

Documents found in this section:

1. Sample Documentation forms
 - a. Consumer Incident Report
 - b. PCA Timesheet
2. Skills Checklist
3. Body Systems Handout
4. Sexual Abuse of Vulnerable Adult Populations

Sample Documentation Form – Consumer Incident Report

Home Resources of Maine, Inc.

Was the HRM employee present when the incident occurred?

Yes

☐

No

☐

Consumer Incident Report

Consumer Name _____ ID # _____ Date of Report _____

Consumer Address _____

Telephone _____ Date of Incident _____ Time _____ am _____ p _____ m _____

Location where incident occurred: _____

HRM Staff Name _____ Telephone _____ Discipline _____

Time In _____ a _____ p _____ m _____ Time Out _____ am _____ p _____ m _____

Witnesses

Name _____ Telephone Number _____

Address _____

Name _____ Telephone Number _____

Address _____

Describe what happened. Give full details of all factors contributing to this incident.

As stated by: _____ HRM Employee _____ Supervisor Signature

Was Physician contacted? Yes ☐ No ☐ If Yes, provide name, address and telephone

What action was taken as a result of this incident?

Was the Emergency Medical System activated? Yes ☐ No ☐

Was the Consumer transported? Yes ☐ No ☐

Did the Emergency Service provide any assistance other than transport? Yes ☐ No ☐

Explain:

Category of Incident	<input type="checkbox"/>	Fall	<input type="checkbox"/>	Motor-Vehicle Accident	<input type="checkbox"/>	Change in Condition
	<input type="checkbox"/>	Injury	<input type="checkbox"/>	Medication	<input type="checkbox"/>	Other:

A. Fall Related to:

Slip	<input type="checkbox"/>	Ambulation Assisted	<input type="checkbox"/>	Consumer vehicle	<input type="checkbox"/>
Trip	<input type="checkbox"/>	Ambulation Unassisted	<input type="checkbox"/>	Employee vehicle	<input type="checkbox"/>
Transfer	<input type="checkbox"/>			Consumer Injury	<input type="checkbox"/>
				Employee Injury	<input type="checkbox"/>

Injury Related to:

Injury in the home other than a fall ☐
Injury outside of the home other than a fall ☐

Motor Vehicle Accident

Medication:

B. Change in Condition Related to:

Conscious verbalized complaints	<input type="checkbox"/>
Conscious exhibiting changed behavior	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>

Other:

Explain:

Other Comments:

Counseling:

Name of Care Coordinator notified: _____ Date : _____

Name of Consumer Contact Person notified: _____ Date : _____

Signature of HRM Supervisor filing this report Date Signed

Signature of Program Manager Date Signed

Program Manager Comments:

Signature of Quality Services Manager Date Signed

Sample Documentation Form – PCA Timesheet

HOME RESOURCES OF MAINE, INC. ~ TIMESHEET AND SERVICE RECORD

CONSUMER TOWN OR CITY _____
CONSUMER _____

EMPLOYEE NUMBER _____
YOUR NAME _____

Week #1 _____ to _____

You must check off all tasks completed each work day

								Week #1							Week #2							
WEEK DAY	DATE	IN	OUT	AM PM	HRS WRKD	MILES		S	M	T	W	T	F	S		S	M	T	W	T	F	S
							Tub/shower															
SUN							Sponge Bath															
							Assist with Dressing-Teds															
MON							Assist with Eating															
							Assist with Toileting															
TUE							Assist with Transfer															
							Assist with Walking															
WED							Bed Mobility															
							Combing Hair															
THU							Shampoo/Shave															
							Oral Care															
FRI							Nail Care															
							Other															
SAT																						

Week 1 Totals _____ / _____

Week #2 _____ to _____

WEEK DAY	DATE	IN	OUT	AM PM	HRS WRKD	MILES		S	M	T	W	T	F	S		S	M	T	W	T	F	S
							Routine Housekeeping															
SUN							Laundry															
							Errands /Appointments															
MON							Grocery Shopping															
							Change Bed Linen															
TUE							Meal Preparation															
							Transport Consumer															
WED							Other															
THU																						
FRI																						
SAT																						

OFFICE USE ONLY

Substation _____
Payor _____
Approved by _____
Mileage \$ _____
Approved by _____

Week 2 Totals _____ / _____

Grand Total _____ / _____

Hours Miles

Consumer Signature _____ Date _____

Employee Signature _____ Date _____

HMK – PCA **Circle One**

Timesheets must be post marked no later than _____

Skills Checklist

Student: _____ Start Date: _____ Completion Date: _____

Skill	Present and/or Demonstration Date	Satisfactory Performance Date	Instr./ Observer Initials	Skill	Present and/or Demonstration Date	Satisfactory Performance Date	Instr./ Observer Initials
I. Infection Control				IV. Care of the Client			
A. Hand Washing				A. Unoccupied & Occupied Bed			
B. Gloving				B. Complete/Partial Bed Bath			
C. Gowning				C. Tub/Shower Bath			
D. Masking				D. Shaving			
E. Eye Protection				E. Foot Care			
F. Removal & Disposal of Equipment				F. Nail Care			
II. Safety & Fire Prevention				G. Hair Care			
A. Side Rails				H. Shampoo Bed/ Tub/Shower			
B. Fire Extinguishers				I. Dress/Undress			
C. Home Safety Check				J. Mouth Care			
D. R.A.C.E.				1. Natural Teeth			
E. Evacuation Plan				2. Dentures			
F. Oxygen				3. Special Mouth Care			
G. Hazardous Substances				K. Care of Hearing Aid /Glasses Contact Lenses			
III. Body Mechanics & Back Safety				V. Skin Care			
A. Standing				A. Back Rub			
B. Bending				B. Decubitus Prevention and Care			
C. Lifting				C. Incontinence Care			
D. Pulling & Pushing				D. Peri Care			
E. Sitting				VI. Transfer/ Transport			
1. Moving Client in Bed				A. Stand/Pivot			
2. Moving Helpless Client Side-Side				B. Bed/Chair/ Wheelchair /Commode			
3. R.O.M.				C. Transfer Board			

Student: _____ Start Date: _____ Completion Date: _____

Skill	Present and/or Demonstration Date	Satisfactory Performance Date	Instr./Observer Initials
D. Gait Belt			
E. Ambulation One/Two Assist			
F. Crutches/Walker/Cane			
G. Mechanical Lift			
VII. Nutrition			
A. Prepare Client Meals			
B. Serve Meals			
C. Assist with Feeding			
D. Supplemental Feeding			
E. Care/Maintenance of Feeding Tube			
F. Therapeutic Diets			
G. I & O			
H. Planning/Purchasing and Storing Food			
VIII. Bowel & Bladder Elimination			
A. Assist with Bedpan/Urinal/Commode			
B. Indwelling Catheter Care			
C. SP Catheter Care			
D. Change Drainage Bag			
E. Record Stool/Urine Output			
F. Empty & Record Urinary Drainage Bag Output			
G. Colostomy Care			

Skill	Present and/or Demonstration Date	Satisfactory Performance Date	Instr./Observer Initials
IX. Special Procedures			
A. Assist Client with Orientation			
B. Become Familiar with Client Care Worksheet			
C. Use of Anti- Embolism Stockings			
D. Medication Reminding			
E. Explains Procedures to Client			
F. Gathers All Equipment Needed Prior to Performing the Procedure			
G. Ensures Client is in Appropriate Position for Procedure			
H. Heimlich Maneuver			
X. Environment/Home			
A. Homemaking			
B. Work Plans			
C. Household Chores			
D. Money Management			
XI. Vital Signs			
A. Temperature			
B. Pulse			
C. Respirations			
D. Blood Pressure			
ADDITIONAL REQUIREMENTS			

Page 2 of 3

Student: _____ Start Date: _____ Completion Date: _____

NOTES AND/OR COMMENTS

[illegible]

SIGNATURE(S) AND TITLE(S) of INSTRUCTOR(S)/OBSERVER(S)

Initials	Signature and Title	Initials	Signature and Title

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Body Systems Handout

14 pages

SYSTEM	FUNCTION	ORGANS	DISEASES	SIGNS AND SYMPTOMS	CARE (may include)
Respiratory			COPD/Emphysema/chronic bronchitis	Breathlessness, wheezing.	Follow doctors orders, oxygen may be needed.
	Oxygen/Carbon Dioxide	Mouth, Trachea, R Bronchus	Asthma	Episodes of breathlessness, wheezing or dry cough	Follows doctor's orders. Position upright to aide breathing. Pace ADL & IADL activities.
	exchange between environment and the body	L Bronchus, Bronchioles	Bronchitis	Phlegm-producing cough that generally worsens - hoarseness & breathlessness may occur.	Encourage clearing of mucous by coughing; Accurate reporting of skin color, breathing rate, color of mucous, productive vs. dry cough.
		Alveoli	Cancer	Chronic cough - blood streaked sputum.	Report signs and symptoms to supervisor.
			Tuberculosis	Chronic, recurrent infection most commonly found in the lung - enlarged lymph nodes	Encourage medication compliance and reporting of yellow/green mucous to supervisor for follow-up.
			Cold/flu	Runny nose, sore throat , headache, cough, muscle pain, fever. Infection caused by droplets released by coughs and sneezes.	Good hand washing is critical to prevention. Encourage fluids. Monitoring temp may be needed.
Cardiovascular	Pumps blood around body	Heart, arteries, veins,	Angina	Shortness of breath, pale-blue tinged skin.	Encourage rest periods and pacing activities. Positioning upright for breathing

	Nourishes cells with oxygen	capillaries	High Blood Pressure	Irregular pulse or increased pulse, chest pain. Swelling in lower legs, dizziness.	Assist with ADLs/IADLs. Follow low salt diet restrictions,
	Controls body temperature		Heart attack (myocardial Infarct)	Prolonged heavy pressure or squeezing pain in the chest behind the sternum. Pain may spread to left shoulder or down the left arm.	Prompt diagnosis within the first few hours following the attack. Call 911 and your supervisor immediately!
			Peripheral vascular disease	Legs may swell. Consumers have decreased sensation and difficulty healing open areas on the legs and feet.	Encourage consumers to elevate their feet - consumers should be encouraged not to cross their ankles. Follow doctor's orders.
			Anemia	Tire's easily, and needs extra time to accomplish tasks.	Encourage small, frequent meals. Daily activities should be planned with regular rest periods.
			Blood diseases (HIV/AIDS)	In the beginning stages of HIV, consumers may have no symptoms. In the late stages of AIDS, consumers experience weight loss, night sweats, fever, diarrhea and skin lesions. Loss of resistance to infections and some cancers	Spreads by sexual intercourse or infected blood. Use strict Universal Precautions. Doctor will prescribe a drug therapy plan.
			Congestive Heart Failure	Blue tinged skin, tires easily, periods of breathlessness,	Monitor vital signs for increased pulse and respirations. Input/Output and weight should be monitored.

				edema	
			Phlebitis	Inflammation of the vein, pain and tenderness along the vein, swelling and edema at the site.	Report signs and symptoms to supervisor. Follow doctor's orders. Encourage rest, elevation of the affected limb, and antiembolic stockings if prescribed.
Digestive	Break food down into nutrients the body can use to nourish cells. Excrete feces	Mouth, Esophagus, Stomach	Constipation/Diarrhea	Nausea, vomiting, blood in vomit, blood in stools,	Encourage consumer to follow therapeutic diet, regular eating times and medication compliance
		Sm. Intestine, Large Intestine	Cancer of all organs	Pain in stomach, difficulty swallowing, poor appetite, changes in energy levels, and patterns of bowel excretion.	Follow doctor's orders.
			Hernias	Hiatal hernia - chronic pain may be related to the regurgitation of acidic gastric content. Inguinal hernia - occurs when a segment of the bowel pushes through the inguinal ring in the groin area.	People may live many years with a hernia, however, if they are having a significant amount of pain, surgery may be needed.
		Liver, Pancreas, Gall Bladder	Ulcers	Open sore or lesion or lesion of the skin or mucous membrane. If infected, pus is formed.	Depending on where the ulcer is located, the consumer may need to be turned frequently, or the affected limb kept elevated.
		Hormones	Diabetes	Excessive urination	Consumer should follow their

		, Glands		,hunger and thirst	recommended diet, the intake of sweets should be discouraged. Insulin injections may be necessary.
Urinary	Excrete urine from body. Maintain fluid balance	Kidneys, ureters, bladder	Cancer	Pain on urination, foul smelling urine, incontinence, no urination (retention), fullness in bladder area, sudden, intense pain	Follow the physician's orders.
		urethra	Infection	Lower back pain, pain/burning on urination, elevated temperature, difficulty urinating, urinary frequency especially in small amounts .	Report signs and symptoms to your supervisor. Observe for adequate intake of fluids and regularity.
			Kidney disease/stones	Intense pain in the back, or when a person urinates.	Report symptoms to your supervisor. Follow the doctor's orders.
			Incontinence	The leaking of urine	More common in women than men. Consumers need to have good peri care. Consumers may wait too long to go to the bathroom, and may need to be put on a toileting schedule.
Skin	Protection from environment	Skin, Hair follicles, Hair	Burns	Observe for consumer's normal skin variations	Depending on the depth of the burn, you may be asked to assist in care. A 1st degree burn could be from a sunburn or small contact burn from cooking. Clean skin daily but not always with soap, and leave the area open to air for healing.
	Vitamin absorption	Glands	Cancer	Skin changes.	Report changes in skin or moles to you supervisor.
	Heat regulation		Eczema	Itching, red skin and small blisters that burst, leaving the	Follow the doctor's orders

				skin surface moist and crusty.	
	Sensory organ		Psoriasis	Inflamed areas, red or pink skin, plaques with silvery, scaly surfaces. Usually found on the elbows, knees, shins, scalp, and lower back.	Follow the doctor's orders.
			Decubitus Ulcers	Reddened to open or broken skin, often on bony prominences. Vary in depth and are called Stage 1-4 ulcers.	Do not rub reddened skin; wait and observe for redness to clear; if it does not blanch back, a stage 1 ulcer may exist. Keep consumer off that area until redness resolves. Keep skin dry, moisturized at all times. Consumers should change their positions at least every 2 hrs.
Skeletal	Structural support of body	Bones	Leukemia	Anemia, fatigue, fever, and bone and joint pain.	Follow the doctor's orders. Consumers tire easily, and daily tasks need to be done based on level of energy. Consumers need good supportive care. Protect consumers from infections whenever possible.
	Blood cell production	Joints	Osteoporosis	Pain, swelling of joints, decreased range of motion of joints, extreme fatigue. Most commonly found in women. Most commonly found in women.	Report signs and symptoms to supervisor. Protect from falls as bones are brittle and fracture easily.
	Calcium storage		Arthritis	Inflammation in one or more joints that causes pain and restriction of movement.	Good posture and body mechanics are important. Encourage ROM exercises if this has been prescribed. Maintain proper body alignment. Follow the doctor's orders for pain management.
			Bursitis	Inflammation and	Initially, rest and immobilize the affected

				pain in connective tissues surrounding the joints.	part. Heat and analgesics will help. After the acute symptoms have passed, limited ROM will be helpful. If symptoms persist, the consumer should seek medical attention.
Muscular	Movement of body	Muscles	Sprains, strains	Pain, aches, swelling of the muscle.	Caused by over use or sudden pulling of a muscle. Initially, rest and immobilize the affected part. Heat and analgesics will help.
	Flexibility of body		Muscular Dystrophy	Weakness of spinal muscles and a gradual decline of muscle function. Observe for weakness and decreased endurance.	Tasks need to be spaced out to help the client conserve energy. Promote the use of assistive devices.
Nervous	Transmit messages between	Brain	Degenerative Diseases (involving destruction of nerves in body)	Problems with communication, thinking and decision-making. Prolonged weakness, dizziness, headaches or drowsiness after a restful sleep	Observe for safety issues with ambulation.
	environment and brain;	Spinal cord	Stroke/TIAs	Not able to move part of their body, decreased vision or speech may be impaired. TIA's happen quickly and last from 2 - 30 sec. Functional ability is usually not impaired. A more serious stroke needs immediate medical	BP should be monitored. Report symptoms such as headaches, followed by increasing neurological deficits immediately to your supervisor or call 911. A home safety evaluation to assess the environment may eliminate falls. Scatter rugs and clear pathways will help prevent falls.

				attention.	
	brain and body	Nerves	Alzheimer's Disease	Begins with mild memory loss, and progresses to a deterioration of intellectual function. Consumers depend on others to perform ADLs & IADLs, and may have seizures, hallucinations, delusions, paranoia and depression. The end stage of this disease is terminal. Consumers experienced a slowed thought process.	A home safety evaluation to assess the environment may eliminate falls. Removing scatter rugs and having clear pathways will help prevent falls. The PSS needs to allow the consumer to do what they can. A structured routine to daily activities may help the client function to their optimal ability. Reality orientation may work in the earlier stages of the disease, but may not work as disease progresses. Patience and understanding will aid the PSS when caring for a person with Alzheimer Disease.
	Control of body systems		Multiple Sclerosis	A range of disabilities affecting movement, vision, speech and function. It may be caused by the body's immune system attacking the person's Central Nervous System. May experience urinary retention, double vision, tremors, cognitive deficits, and mood disorders.	Avoid over-exertion, exposure to extreme hot and cold and stressful situations. Encourage consumer to follow a regular schedule of daily activities and exercise. Clients may tell you that they have "good and bad" days and need to be reserve their energy whenever possible. A home safety evaluation to assess the environment may eliminate falls. Remove scatter rugs and keep clear pathways to prevent falls.
			Lou Gehrig's Disease (ALS)	Muscle weakness and muscle atrophy (wasting, decrease in size of the muscle)	A rehabilitation program can help the client maintain their independence. As mobility decreases, the client will need to be turned frequently to prevent skin

				This is a terminal disease.	breakdown. Encourage the use of assistive devices. Alternative methods of communication may be needed as disease progresses.
			Parkinson's	Stiffness and trembling of the muscles. It also interferes with walking, speech and facial expressions.	Usually on a drug treatment program, and the medication schedule is very important to maintain consistently. Plan daily activities to prevent fatigue. PT & OT referrals may be beneficial. A home safety evaluation to assess the environment may eliminate falls. Remove scatter rugs and keep clear pathways to help prevent falls.
			Spinal cord Injury/Head Injury	Disability will be determined by the severity of the injury. There are partial cord injuries and complete cord injuries. The higher and more complete the injury, the greater the damage to the nervous system.	Consumers should be encouraged to maximize their abilities whenever possible. For high cord injuries, the consumer will be very dependent and the PSS will need to meet most of their ADLs, IADLs needs. Good skin care and ROM exercises will be critical for the client.
			Dementia	Forgetfulness, memory loss and a decrease with intellectual function.	Client may benefit from cues and reminding to accomplish ADLs & IADLs. Client may wander and get lost in their own home. Reality orientation may be helpful in early stages. Patience and understanding will aid the PSS when caring for a person with Alzheimer Disease.
			Anxiety	A feeling of apprehension, worry, uneasiness or dread. The source is often nonspecific or unknown.	Encourage the client to express their feelings and concerns. The PSS should be calm and caring. Clear, simple validating statements are helpful. If the stressor is known, it should be avoided.

				Excess anxiety interferes with the client's ability to function.	
			Depression	Loss of interest in all usually pleasurable outlets, such as food, friends and hobbies. The consumer may have feelings of worthlessness, concerns with death, and may attempt self injury.	The PSS should be warm and caring and maintain a positive attitude, while not be overly cheerful. Report any and all threats of suicide to your supervisor immediately.
			Schizophrenia/ Bipolar Disorder	A chemical disorder in the brain. that alters the person's insight or perception with thinking, language, communication, behavior, affect, social functioning and attention.	Medication is used to control the symptoms. The consumer may experience hallucinations, delusions, thought disorder and bizarre behavior. They may hear voices or talk to no one.
Lymphatic System	Protects the body from infections and includes a vast network of vessels	Vessels	The lymphatic system includes all the lymph vessels that collect the tissue fluid and returns it to the blood vessels.	Enlarged lymph nodes, fever, fatigue	
			Hodgkin's Disease	Painless enlarged lymph nodes beginning in the neck, under the arm, in the groin,	Consumer should seek medical attention. Comfort measures should be provided and relaxation encouraged. A soft toothbrush should be used to decrease gums from bleeding. Once treatment has

				chest and abdomen. There may also be swelling, fever, night sweats, loss of appetite and weight loss.	been started, good nutrition, frequent small meals and good fluid intake should be encouraged.
			Leukemia	Cancer of the bone forming cells of the bone marrow. These cancer cells become widespread in the blood and especially in the liver, spleen and lymph nodes. The client may experience anger, anxiety, fear and depression. May have fever, chills, sore throat or cough.	Good skin and oral care. A soft toothbrush should be used to decrease gums from bleeding. The skin and rectal area should be kept clean, and lotion is often recommended to prevent drying or cracking. Try to keep the client removed from infections or infectious diseases. Good supportive care is needed, including managing fever, pain and bleeding.
			Tuberculosis	May not have symptoms in the early stages, and may complain about not feeling well. A cough is the most common symptom, but may be overlooked if the consumer smokes. Mucous produced cough may begin turning yellow, and then green. This is usually seen in the mornings when the client gets out of bed. Mucous	Client should seek medical attention and treatment. Medication can be given. Masks may be necessary for those having intimate contact with a consumer who is just beginning chemotherapy, and in caring for consumers who cannot or will not take precautions against spreading the infection. Usually, two to four weeks after medications are begun restrictions are removed regarding activities and contacts. Hand washing is essential to prevention of cross-infection. Gloves are worn when touching infective material. No special precautions are required for eating utensils and other inanimate articles in the patient's room. Screening of family members and other contacts should be done.

				becomes more productive as the disease progresses.	
			Syphilis	Fever, usually less than 101, sore throat, fatigue, weight loss and enlarged lymph nodes. This may cause an infected person to delay seeking medical care or may make diagnosis difficult. Initial lesions appear 3-4 weeks after becoming infected.	Penicillin is the antibiotic of choice. Syphilis cannot be spread through contact with toilet seats, door knobs, swimming pools, hot tubs, bathtubs, shared clothing, or eating utensils. Syphilis is contagious whenever an open sore or skin rash is present. You should report the following findings to your supervisor: any sores, bumps, rashes, blisters, or warts on or around the genital or anal area or on any area of the consumer's body if you think they could be caused by a sexually transmitted disease.
Reproductive System - Female	Birth and Sexuality	Female: Vagina, Uterus, Fallopian tubes, Ovaries	Infertility	Affects both men and women. This condition will interfere with the woman's ability to become pregnant. Symptoms may include pain. For the male, this could be caused by abnormal sperm, inability to pass the sperm, infection or ejaculation problems.	Medical evaluation and treatment may help.
			Cancer		
			Ovarian	Ovarian cancer is rarely detected in	Comfort care measures

				the early stages. Symptoms appear usually when the cancer has spread to other organs, and may include pain, discomfort and abnormal vaginal bleeding.	
			Cervical	Often there are no symptoms for the early stages of this disease. As the disease progresses, there may be some blood stained discharge from the vagina.	Women should be encouraged to have annual Pap tests for women age 18 and older. The physician may recommend Pap tests at a different frequency, once it's been established that the woman has had a number of yearly negative Pap tests.
			Endometrial/Ut erine	Abnormal bleeding from the uterus	Most likely a Hysterectomy = surgical procedure:
			Endometriosis=d isorder of the uterine lining.	Bleeding and pain.	The consumer should seek medical attention if symptoms persist.
		Breasts	Cysts = fluid- filled sacs	Breast lumpiness and/or pain, usually associated with the woman's menstrual cycle. Most lumps are non-cancerous, however, a painless lump may indicate cancer. Males can also get breast cancer and should do monthly breast self examination. Lumps should be reported to the	Monthly breast self examination (BSE) should be encouraged by the clinician. An annual clinical breast exams should be done by a physician for women 40 and older.

				clinician.	
Reproductive System - Male	Birth and Sexuality	Males: Testes	Testicular disorders	Most common symptom is swelling.	The man should seek medical attention if it is associated with fever or infection.
			Testicular cancer	First symptom is usually a firm, painless swelling. Some men may have pain and swelling too.	The man should seek medical attention.
		Prostate	Enlarged prostate	Very common in men over 50. This may constrict the flow of urine. The bladder may become distended.	The man should have an annual physical. The man should seek medical attention if voiding becomes a problem.
			Prostate cancer	There may be no symptoms in the early stages. As the tumor grows, the man may will have difficulty urinating. This cancer can spread to the ureters, kidneys and bladder.	The man should seek medical attention.
		Penis	Urethritis	Inflammation of the urethra, usually caused by a sexually transmitted infection and the man may have a discharge from the penis and pain on urination.	The man should seek medical attention.
			Genital herpes	Small clusters of blisters will develop on the penis and can cause painful ulcers.	The man should seek medical attention.

			Impotence	A man's inability to achieve or maintain an erection.	There are treatable conditions for this problem. The man should seek medical attention.
Endocrine System	Glands	Parathyroid, thyroid,	Goiter	Goiter occurs widely in certain geographic regions where the food or water is deficient in iodine. This is indicated by an enlarged thyroid gland.	Follow the doctor's recommended plan
		pituitary, testes/ovaries and	Diabetes	Symptoms include being thirsty, an increased appetite and increased urination.	Follow the doctor's recommended plan. Foods with high sugar content should be discouraged. Offer good skin care, clients should be encouraged to wear cotton socks. Their clinician should examine their feet during medical appointments.
		pancreas	Dwarfism	The consumer will be of short stature	No special care needs, other than treating the consumer as a normal human being. Consumer may have some issues with proper body alignment.
			Giantism	Exaggerated skeletal growth. The consumer may experience soft tissue swelling and swelling of the nerve endings.	Depending on the symptoms, surgery, radiation therapy or medical management may be needed.
Sensory System	To see, hear, taste and feel	Ears, eyes, tongue, skin	Blindness, deafness, loss of		
			smell, hearing,		
			sensation, taste		

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Sexual Abuse of Vulnerable Adult Populations

GUIDELINES FOR FACILITIES:

Sexual Abuse of Vulnerable Adult Populations

March 2003

**Department of Human Services
Department of Behavioral and Developmental Services**

John Elias Baldacci
Governor

INTRODUCTION

“Sexual abuse or exploitation” means contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult’s consent. “Sexual abuse or exploitation” may also include being pressured to engage in sexual activity. Included in this definition is sexual contact with persons who are not able to communicate their unwillingness.

Sexual involvement by care providers or mental health professionals with their clients is inappropriate, exploitive, and is always illegal whether or not the adult consents. Sexual abuse occurs whenever force or coercion is used, even if the perpetrator is a resident of the facility or a spouse or partner of the resident being abused.

Do not wait until an assault actually occurs to learn the correct procedures. Having this information on hand will decrease the time it takes for the resident who has been sexually assaulted to receive assistance. The first response to this person can significantly help or hinder recovery from the trauma of sexual assault. Sexual assault is an aggressive act that puts the victim/survivor in a potentially life-threatening situation, and causes emotional trauma. Remember that attempted rape has the same psychological consequences as a completed rape.

Persons with developmental disabilities are more vulnerable to the crime of sexual assault than the general population. They are praised for their compliance, making them easily led or persuaded by others. They often have not been educated about safety, appropriate sexuality, or basic rights, and go to great lengths to be accepted. They also rely heavily on caregivers and live in high-risk environments.

HOW TO RECOGNIZE POSSIBLE SEXUAL ABUSE

Signs that sexual abuse may have occurred recently:

- **Bruises in genital area**
- **Genital discomfort**
- **Sexually transmitted disease**
- **Signs of physical abuse (bruising, cuts, pains)**
- **Torn or missing clothing**
- **Unexplained pregnancy**
- **Avoidance of specific settings or individuals**
- **Withdrawal**
- **Sleep disturbances**
- **Regression**
- **Headaches**
- **Excessive crying spell**
- **Noncompliance**

Signs of possible past sexual abuse:

- **Depression**
- **Sleep disturbances**
- **Response to “triggers”**
- **Substance abuse**
- **Atypical attachment**
- **Noncompliance**
- **Seizures**
- **Poor self-esteem**
- **Eating disorders**
- **Resisting examination, either medical or dental**
- **Self-destructive behavior**
- **Learning difficulty**
- **Sexually inappropriate behavior**

Other possible indicators that sexual abuse has occurred:

- **Devaluing attitudes by caregiver toward resident**
- **Isolation of social unit**
- **Other forms of abuse (physical, emotional)**
- **Seeks isolated contact with children**
- **Pornography usage**

Residents who were sexually abused as children or in other settings, may be re-traumatized when they enter a new facility, or by events at a facility. Some “triggers” that may suggest earlier sexual abuse, and may cause re-traumatization, include:

- **Being out of control in a situation**
- **Derogatory or insensitive comments about sexual assault victim/survivors**
- **Television and movie violence**
- **Seeing someone who looks like assailant**
- **People touching or standing close without permission**
- **Being hugged or touched by any adult**
- **Being in a vulnerable position or situation**
- **Sexual advances**
- **Reading or hearing about other sexual assaults**
- **Feeling that people are staring**
- **Action, smell, sound, that reminds client of the assailant or the place where assaulted**

HOW TO RESPOND TO POSSIBLE SEXUAL ABUSE

Immediate steps to be taken if the assault occurred within the past seventy-two hours:

1. Take the resident to the hospital emergency room as soon as possible after the assault. Notify the guardian or durable power of attorney, if applicable. If the resident has a guardian, the hospital shall seek the guardian's permission to provide medical treatment. If a guardian refuses to give permission for medical treatment, a report must be made to the Bureau of Elder and Adult Services.

The medical exam is essential to provide treatment for injuries, gather evidence for possible legal use, and to screen for sexually transmitted diseases and pregnancy. Residents are entitled to a complete rape protocol exam, which is important, since the resident may be too embarrassed or unable to tell everything that happened; however, a resident may refuse to have a complete exam.

Request that the resident not change clothes, wash, douche, go to the bathroom, or have anything to drink or to rinse her/his mouth before the medical exam. The medical exam is also a collection of forensic evidence for possible court proceedings, and will probably require as many as four hours for completion, a process that cannot be interrupted once it has begun.

2. Call the appropriate authorities and resources: (telephone numbers on last page)
 - If the resident is an incapacitated or dependent adult, a report must be made to DHS, Bureau of Elder and Adult Services (BEAS). When BEAS is called, a caseworker may call law enforcement to begin an investigation.
 - If the resident is served in any capacity by DBDS, a sexual assault is considered a *critical incident*. The Regional Director for the area where the assault occurred must be called.
 - Call the statewide sexual assault center hotline. Resident consent for the call should be obtained if possible. A sexual assault center advocate can serve as a designated person to whom the resident and/or caregivers can direct concerns about the assault and its aftermath. The advocate will be knowledgeable about the legal system, medical procedures, and needs of the resident, and can serve as a resource for facility staff as well as the resident. An advocate can be present during the medical exam if the resident and/or guardian agree.
 - The resident has ninety days in which to decide whether to report the crime to the local law enforcement department. Evidence collected

during the medical exam is held for this period of time by a designated agency in collaboration with the hospital where the exam is performed.

- Residents may self-refer to any of the above authorities and resources.

3. Do not touch or disturb the scene of the assault, or remove any items.

4. Remove the alleged perpetrator from contact with the client. It is usually recommended that a facility separate the client and alleged perpetrator pending the outcome of an investigation. Both parties may need protection. A person known to the client, such as a family member, caregiver, bus driver, etc, perpetrates the majority of assaults against people with disabilities. It is preferable to remove the perpetrator rather than the client so as not to reinforce victim blaming.
5. If more than seventy-two hours has elapsed since the assault, physical evidence cannot be collected, but medical attention for the client should be obtained.

Further steps to be taken for the comfort and safety of the client:

- 1. Do not leave the client alone.**
- 2. Offer the client a blanket or something warm to wrap up in.**
- 3. Make no comments implying that the client “asked for it” or is lying. Let the client know that she/he is believed, that the assault was not her/his fault, and that she/he did not cause it to happen. Often a victim/survivor blames her or himself for a sexual assault because of something she or he did or did not do. Reassure the client that only the perpetrator is to blame for an assault.**
- 4. Find something in the client’s story to praise and support. The client may have done something brave, such as yelling or fighting back, but just living through an attack deserves praise. Do not suggest what should have been done, as this undermines self-esteem.**
- 5. Help the client identify feelings about the experience by acknowledging the right to be angry, sad, hurt, or confused. Working through feelings is difficult, especially when the client knows the perpetrator.**
- 6. Some clients want to talk about the incident repeatedly, and some prefer not to talk about it at all. Let the client know that someone is there to listen, and let the client guide how much is said about the incident.**

7. **Help the client decide on a problem-solving plan for dealing with the incident. It is important for the client to choose a plan, if at all possible, in order to regain control. Self-determination is the guiding principle, unless the client's plan represents a danger to the client or to another person.**

SELF-PROTECTION FOR ALL CLIENTS

1. **Help clients learn to trust their feelings about being pressured to have sex**
2. **Help clients understand that they have the right to set sexual limits**
3. **Encourage clients to practice communicating those limits:**
 - **Okay to be rude to someone who is using sexual pressure, even if feelings are hurt**
 - **Okay to get angry when someone does something that is unwanted**
 - **Okay to yell, leave, push or use other means to get away**
 - **Okay to question behavior that doesn't seem right, such as sitting or standing too close, blocking the way, grabbing or pushing, disregarding "NO", staring**

WHAT TO SAY, AND WHAT NOT TO SAY, TO SOMEONE WHO HAS BEEN SEXUALLY ASSAULTED

When trying to support a client who has been sexually assaulted, try not to be judgmental or take control. Recognize how personal values, prejudices and experiences have an impact on the response to a client's sexual assault. A sympathetic ear can make a big difference in the recovery process.

Communicating the following four points is most important:

1. "I'm glad you're alive."
2. "It's not your fault."
3. "I'm sorry it happened."
4. "You did the best you could."

It is also helpful to keep in mind these guidelines:

DO

- **be a good listener**
- **assist the client in getting the help she or he needs and wants, which may mean providing phone numbers, information, transportation, referrals**

DO

- **if the client feels guilty because she or he didn't fight back, tell her or him that fear often inhibits people, and that cooperation does not mean consent**

DO

- **try to minimize the number of times the client must tell the story of the assault**

DO

- **assure the client that it was not her or his fault, that no one asks to be sexually assaulted, and that no one deserves to be sexually assaulted**

DO

- **help the client to know that this experience will cause a disruption in her or his life but that recovery is possible**
- **ask permission before standing close to the client or touching her or him**

DON'T

- **give advice or make decisions for the client, remembering that it is important for the person who has been sexually assaulted to make her/his decisions as a step in regaining control and overcoming feelings of helplessness**

DON'T

- **ask why she or he didn't scream, fight, run**
- **make suggestions about what could or should have been done**

DON'T

- **prevent the client from talking about the assault if she or he wants to**

DON'T

- **ask the client if she or he did anything to "lead the perpetrator on"**
- **ask the client what she or he was wearing**
- **ask the client any questions that begin with the word "why"**

DON'T

- **stare**
- **blame the client for what happened**

IMPORTANT TELEPHONE NUMBERS

Maine Coalition Against Sexual Assault 1-800-871-7741
(MeCASA) Connects to local area center 1-888-458-5599 (TTY)

Adult Protective Services Intake
Bureau of Elder and Adult Services 1-800-624-8404
(V/TTY)

Department of Behavioral & Developmental Services (BDS)
Region I Director 822-0270 828-0272 (TTY)
Region II Director 287-8118 287-4238 (TTY)
Region III Director 941-4360 941-4392 (TTY)

Information regarding Training for staff and/or residents is available through the numbers listed above.

**Guidelines developed as a collaborative effort by Rape Response Services
of Bangor,
The Bureau of Elder & Adult Services, DHS; Trauma Services, DBDS Office
of Program Development;**

NON-DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 1981, 2000d et seq.) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), the Age Discrimination Act of 1975, as amended (42 U.S.C. § 6101 et seq.), Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12131 et seq.), and Title IX of the Education Amendments of 1972, (34 C.F.R. Parts 100, 104, 106 and 110), the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to, or treatment or employment in its programs and activities.

Civil Rights Compliance Office, has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84, and 91), the Department of Justice regulations (28 C.F.R. part 35), and the U.S. Department of Education regulations (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolutions of complaints alleging discrimination may be referred to Civil Rights Compliance Office at 221 State Street, Augusta, ME 04333, Telephone number: (207) 287-2567 (Voice) or 207-287-4479 (TTY), or the Assistant Secretary of the Office of Civil Rights of the applicable department (e.g. the Department of Education), Washington, D.C.

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